



**A QUALITATIVE STUDY EXPLORING THE CHALLENGES EXPERIENCED BY  
TRAINEE PSYCHOLOGISTS WHEN CONDUCTING A FORMAL MENTAL STATUS  
EXAMINATION DURING THE CLINICAL INTERVIEW**

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**2019**

**AS THE CANDIDATE'S SUPERVISOR I AGREE TO THE SUBMISSION OF THIS  
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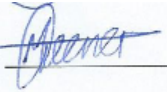
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## **Abstract**

Trainee Psychologists in South Africa undergo comprehensive theoretical and practical postgraduate training within their respective disciplines (Clinical, Counselling, Educational, Industrial and Research Psychology). An aspect of training involves developing competencies in implementing and interpreting the Mental Status Examination. Research in the area of postgraduate professional training has been restricted to disciplines such as medicine and social work. Very little research has been done to understand mental health trainees' experiences regarding their professional development. Specifically, training as a mental health professional involves an evolution of the self as a working apparatus in the assessment and management of a client/patient. The aim of the current study was to explore the challenges faced by trainee psychologists when conducting a mental status examination with an adult client. Data was collected through interviewing trainee psychologists who, at the time of the study, were currently enrolled at the University of KwaZulu-Natal for their Clinical or Counselling Psychology Master's Degree. Eight Participants were interviewed, and the data was analysed using Thematic Analysis. Results indicated that the trainees experienced a number of different challenges when it came to administering the MSE such as difficulty transitioning from theory into practice. This included, but was not limited to, difficulties such as personal challenges and managing the various elements of the MSE. A number of process issues also arose whilst administering the MSE, including difficulties managing the structured and unstructured elements of the MSE and dealing with discomfort surrounding specific MSE questions. In addition to this, trainees described how the characteristics of the clients either aided them in their ability to conduct the MSE (through shared understandings or experiences) or resulted in increased difficulty (differences in age, gender or race were found to negatively impact MSE administration). Similarly, culture and language was found to play both a positive and negative role when it came to administering the MSE. Some trainees found that cultural similarities enhanced their ability to conduct the MSE, whilst others found that it hindered them in conducting the MSE. Enhanced understanding of these challenges allows for training institutions to reflect on their Psychology Master's training programmes, which in turn allows for Professional programme co-ordinators to take cognisance of these challenges when engaging in skills development training.

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# CHAPTER ONE

## INTRODUCTION

### 1.1 What is the nature and scope of the problem?

A trainee psychologist enrolled at the University of KwaZulu-Natal (UKZN) typically begins their training by attending numerous seminars during the first five weeks of the course, known as the orientation programme. During this period, the primary objective of the orientation is to expose the trainees to the first interview through seminar discussions and through role-plays. This enables the trainee psychologist to learn how to conduct the initial assessment interview with a client, preparing them for the therapeutic settings in which they will be working.

According to Morrison (2014) in his book, *The First Interview*, the initial assessment interview is made up of numerous sections such as the history of the presenting problem, relationship dynamics, personal and social history, educational history, family history to name but a few, and this in turn is utilised to accomplish varying goals. Similarly, Groth-Marnat (2003) states that the assessment interview can yield, “valuable information that may be otherwise unobtainable, such as behavioral observations, idiosyncratic features of the client, and the person’s reaction to his or her current life situation” (p. 69). The general goals of the assessment interview outlined by Groth-Marnat (2003) are to gather information which cannot be easily obtained, establish a working relationship with the client, develop a greater understanding between both the interviewer and interviewee regarding the client’s problem behaviour and lastly to provide any direction and support in relation to the client’s problem behaviour. Furthermore, Morrison (2014) notes that this initial assessment interview usually takes an experienced clinician an hour to complete and possibly several hours for a trainee to complete.

Groth-Marnat (2003) notes that the assessment interview has both the flexibility and structure, to enable users to capture content in a meaningful and productive (building a therapeutic alliance) manner. The outcome of which would facilitate generating clinical information to inform the clinician’s hypotheses, potential diagnoses and/or treatment plan. The major sections of the initial assessment interview outlined by Morrison (2014), coupled with the amount of time (expressed as a percentage) that should be devoted to each aspect of the interview are as follows:

- 1) 15%: Determine the chief complaint and encourage free speech.



- 2) 30%: Pursue specific diagnoses; ask about suicide, history of violence, and substance misuse.
- 3) 15%: Obtain medical history; conduct review of systems; obtain family history.
- 4) 25%: Obtain rest of personal and social history; evaluate character pathology.
- 5) 10%: Conduct mental status exam.
- 6) 5%: Discuss diagnosis and treatment with patient; plan next meeting.

This leaves the trainee with 10% of their time devoted to the Mental Status Examination (MSE), including both the observation and semi-structured elements of the MSE. Observation is a key element of the MSE, beginning as soon as the trainee first meets the client and continuing throughout the rest of the initial assessment interview. Thus, the MSE may provide a whole host of challenges for the trainee psychologist to navigate, such as managing their time and incorporating their new skills and knowledge in order to gain as much accurate information about the client's history, as well as about their current mental state. Time for exploration of trainees' thoughts and experiences around conducting the MSE is not a major focus during this training period. Hill, Sullivan, Knox & Schlosser (2007) noted that trainees experience a vast range of difficulties when it comes to interviewing clients. Scenarios such as not knowing where to start in the clinical interview, feeling pressured to 'do the right thing' and being able to transition from story-telling to information-gathering are just some of the challenges that trainees face when conducting the initial interview. In addition to this, it would be beneficial to understand how the trainees themselves assess difficulty and how they make sense of it whilst conducting the MSE. Much emphasis is placed on rapport building and obtaining a relevant and accurate history; the mental status examination has been included as a "staple of the initial mental health examination" (Morrison, 2014, p. 117), and is thus a crucial aspect of the initial assessment interview.

According to Groth-Marnat (2003), the MSE was originally modeled after the physical exam, and just as the physical exam is designed to review major organ systems, the MSE reviews the major psychiatric functions of a client (such as their self-care, cognitive functioning, insight etc). The MSE was first introduced into American Psychiatry by Adolf Meyer in 1902, and since that time it has become "the mainstay of patient evaluation in most psychiatric settings" (Groth-Marnat, 2003, p. 85). The MSE's role in psychiatry, as described by Groth-Marnat (2003), takes

on a number of different roles: it can be used to determine whether a more formal psychological test is needed, it can be used to determine if a client needs to be hospitalized or placed under observation or it can be used as a part of an assessment using formal psychological tests. It is important to note that Gorth-Marnat (2003) states that most psychologists do not use such a formal version of the MSE, but instead the MSE may be incorporated as a part of the overall assessment interview. The Mini Mental Status Exam (MMSE), not to be confused with the MSE, has psychometric properties as an assessment of current neuropsychological functioning and also has its origin in the field of medicine (Sadock and Sadock, 2009). It can thus be seen that the Mental Status Examination forms a crucial aspect of the initial assessment interview and it is necessary for trainee psychologists to be able to manage both the observation and semi-structured element in order to gain valuable information about the client.

It has been well documented in the literature that trainee psychologists experience a multitude of problems and challenges whilst in the process of training (Kanazawa & Iwakabe, 2015; Hill et al., 2007; Pascual-Leone, Wolfe & O'Connor, 2012). Some of these problems include self-criticism around competence, negative emotional reactions to clients and difficulties in applying practical skills (Hill et al., 2007). Pascual-Leone, Wolfe & O'Connor (2012) suggested that challenges faced by trainee psychologists could be broken into two major categories, namely: professional development and personal or self-development. Professional development includes aspects such as the ability to apply theory and skills in a therapeutic setting, the trainee experiencing themselves as a therapist, developing a therapeutic presence and formulating goals which would lead to further professional development. Self-development was described by Pascual-Leone, Wolfe & O'Connor (2012) as personal growth and relating to others. Other challenges such as finding and keeping focus, feeling ineffective, struggling to keep the flow of conversation in therapy and feeling one's personal style being in conflict with the therapist's role were also discussed by Pascual-Leone, Wolfe & O'Connor (2012). In addition to this, further knowledge is needed around therapeutic alliance dynamics and whether or not they have an impact on the way that trainees administer the MSE.

Feelings of incompetence consistently appear in the literature around challenges faced by trainee psychologists, as mentioned above. Thériault, Gazzola & Richardson (2009), in their study on 10 novice counsellors, found that incompetence was central to the challenges faced by the trainees.

However, they also found that incompetence was oftentimes used by the trainees to motivate them to learn more about themselves and to gain more knowledge around counselling skills. Despite this, feelings of incompetence often left the trainees feeling immobilized, self-conscious and vulnerable during sessions with clients.

Kanazawa & Iwakabe (2015), in their study conducted on Japanese graduate psychology trainees, found similar themes such as ‘feelings of incompetence’ as well as ‘difficult relationships’. All of the participants in Kanazawa & Iwakabe’s (2015) study reported a broad range of difficulties that occurred specifically in conflictual relationships with supervisors, colleagues, and mental health practitioners at their practicum sites. Feelings of incompetence were found by Kanazawa & Iwakabe (2015) to occur when trainees would compare themselves to their colleagues or when they felt that they lacked competence during sessions with clients. In addition to this, trainee’s multiple roles as students and clinicians were another source for a perceived ‘lack of competence’, as described by Kanazawa & Iwakabe (2015). “Being both a graduate student and clinician was difficult. My cases were going on, were becoming more intense, I had to think about them, but the deadline for my master’s thesis was getting close. That was terrible.” (Kanazawa & Iwakabe, 2015, p. 286). Trainees encountered difficulties applying clinical skills such as interpreting psychometric assessments, behavioural observations, developing rapport with clients and maintaining confidentiality. This then led to further feelings of incompetence (Kanazawa & Iwakabe, 2015). Similarly, Hill et al. (2007) found that difficulties with self-awareness, worrying about therapeutic abilities, discomfort with the therapist role and a lack of clinical skills led to trainees feeling more self-critical and increased their feelings of incompetence.

Difficult or problematic relationships, as described by Kanazawa & Iwakabe (2015), relate to relationships with supervisors, colleagues and other mental health practitioners in practicum sites. These challenges, as Kanazawa & Iwakabe (2015) described, were more practical in nature and were, for the most part, out of control of the trainees. Things such as poorly developed training systems at practicum sites, personal conflicts between colleagues and supervisors and a lack of structure in supervision all contributed to the difficulties faced by trainee psychologists.

It has been suggested there are many difficulties and challenges which trainee psychologists face throughout their training, which, as Kanazawa & Iwakabe (2015) note, can have a major impact

on the personal and professional development of trainee psychologists. In light of this, it is important then to understand the direct experiences of the trainee psychologists themselves, as insight into the challenges which they face during training will allow for improvement in these areas and ultimately an improvement in their training. The Mental Status Examination, as it has been noted, is a crucial assessment tool that the trainees need to become familiar with in a short period of time, and so an exploration of the challenges that trainees face when using the MSE is a crucial step towards understanding and improving existing training programmes. The stage model of counsellor development developed by Skovholt & Ronnestad (1992) will be used as the conceptual framework through which the experiences of the trainees will be understood, placing the challenges that the trainees experienced in relation to the stage in which they found themselves during the study. The focus of this dissertation is to explore the challenges faced by trainee psychologists during the assessment interview, particularly in relation to conducting the mental status examination.

## **1.2 Terminology**

**Trainee Psychologist:** For the purposes of this study a Trainee Psychologist will be considered a student who is currently registered for a coursework masters in Clinical or Counselling Psychology at the University of KwaZulu-Natal, as well as being registered as a Student Psychologist with the Health Professions Council of South Africa.

**Mental Status Examination (MSE):** The Mental Status Examination is an interview screening evaluation which considers all of the important areas of a patient's current emotional and cognitive functioning and is often augmented with some simple cognitive tests.

# CHAPTER TWO

## *LITERATURE REVIEW*

### **2.1 The Mental Status Examination**

The Mental Status Examination (MSE), as previously described, is an incredibly important aspect of the initial assessment interview. Simply put, the MSE is an “interview screening evaluation of all the important areas of a patient’s current emotional and cognitive functioning, often augmented with some simple cognitive tests” (Daniel & Gurczynski, 2010, p. 61). The MSE is thus very useful at providing psychologists with rich information when formulating a client’s diagnosis. As noted above, the MSE requires the psychologist to pay attention to and observe the client’s verbal and non-verbal behaviours, as well as to ask them specific questions in order to evaluate their current mental state. One might wonder whether a heavy reliance on observation (which is highly subjective) may lead to unreliable diagnosis. However, Daniel & Gurczynski (2010) note that the purpose of the MSE is to provide a framework in which a comprehensive evaluation of a client’s mental functioning should instead increase objectivity and the reliability of the information. This is further explained due to the high degree of similarity amongst MSE formats, which would mean that amongst trained psychologists there is a general acceptance as to what should be included in the MSE. “A standardized approach increases reliability of the MSE – that is, the likelihood that the patient would be diagnosed the same way by another professional using an MSE” (Scheiber, 2004 cited Daniel & Gurczynski, 2010, p. 61). This standardized approach not only improves the reliability and objectivity of the MSE, but it also allows for trainee psychologists to adapt to a single agreed-upon method to use during their clinical training. This is not the case at UKZN, and instead the trainee psychologists are expected to formulate their own MSE questions in accordance with the various domains covered by a standard MSE. Trainee psychologists are trained in both the observational and formal administration of the MSE, allowing them to become familiar with a standardized method.

### **2.2 Structure and Format of the MSE**

It can be seen that the observation element of the MSE is a crucial aspect, one that the trainee psychologist needs to be familiar with, but what exactly does observation cover? There are a number of different areas covered by observation; the first of these being appearance. The

appearance of a client needs to be rated by the trainee psychologist based on their grooming and hygiene. Daniel & Gurczynski (2010) note that the observation and recording of a client's appearance is necessary not only for that particular MSE, but it can prove to be useful when comparing a client's appearance if they are evaluated again in the future as any manifestation of a change in a client's appearance may indicate a change in their current psychiatric state. Behaviour is the next area covered by observation. Observation of a client's behaviour according to Manley (2009) is rated by the trainee taking note of how the client acts in the assessment interview; things such as being cooperative, oppositional, hostile, seductive, displaying unusual movements, making strange gestures, pacing and breathing heavily may all be included under observation of behaviour. Attitude falls under the observation of a client's behaviour, and is described by Daniel & Gurczynski (2010) as things such as facial expression, posture, eye contact, voice tone, how completely the client answers questions and the client's general willingness to participate in the interview. Mood and affect are important aspects of observation for a trainee to take note of, as these are both central features in common psychiatric disorders. "General *mood* is considered the internal emotional state of the patient and *affect* is the external expression of emotional state" (Daniel & Gurczynski, 2010, p. 70). Generally, a client's mood may be both inquired and observed by the trainee, and it is important to make a note of both euphoric and dysphoric moods (Daniel & Gurczynski, 2010). Congruence of a client's mood and affect are important to observe, otherwise known as inappropriate affect (Rosenthal & Akiskal, 2003). For example, this may be seen when a client laughs whilst talking about the death of a loved one. Speech and language forms another aspect of observation, with the trainee needing to take into account the comprehension of the client, as well as their ability to express ideas adequately in speech (Daniel & Gurczynski, 2010). Thought and perception forms the final observation element which is broken down further into thought form and thought content. Thought form is observed by noting how ideas are linked together, whether the thoughts form a coherent pattern, are logically associated and are goal directed (Manley, 2009). Thought content refers to the ideas that a client expresses. Abnormalities are described as anything out of the ordinary, such as delusions, obsessions or ideas of reference (Manley, 2009). An example of a delusion may be that the client believes the government are watching their every move, which, when taken into consideration of the overall picture painted by the client, may be completely unlikely. Perceptual related observation is concerned with any perceptual disturbances

experienced by the client, such as hallucinations and illusions (Manley, 2009). Most often, some observation elements will need to be further inquired by the trainee, such as gaining more understanding into why a client keeps looking at shadows on the wall for example (possible hallucinations may be occurring, so further inquiry is necessary in such a case).

Rosenthal & Akiskal (2003) state that the presenting problem of a client will determine both the direction and depth of inquiry of the MSE, with more deviant and severely disturbed clients requiring more probing. It is easy to assume that the MSE should follow a structured question-and-answer format. However, Daniel & Gurczynski (2010) state that the MSE should flow and take on a conversational quality, as it is more likely that the client will elicit valid data. Not only this, but rapport should still be a major goal of the psychologist in order to encourage the client's cooperation and openness. Daniel & Gurczynski (2010) draw attention to the importance of the MSE within the context of the entire initial assessment interview, stating that the MSE only provides information of the client's functioning in that moment. This may make the MSE seem less important, as it provides only a snapshot of the client's current functioning. Despite this, the authors go on to say that this snapshot provides crucial information on the client's current functioning and thus it needs to be incorporated into the context of a thorough psychosocial and psychiatric history

Rosenthal & Akiskal (2003) further discuss the importance of the MSE in the context of psychiatric and/or hospital facilities:

“Psychologists are often front-line evaluators, particularly in mental health centers where many of these conditions are seen in their milder forms. It is therefore essential to keep in mind that subtle behavioral abnormalities sometimes are the first indicators of underlying medical illness. The Mental Status Examination can provide important data for differential diagnosis” (Rosenthal & Akiskal, 2003, p. 26).

It is in these medical settings where psychologists are being called on more frequently to collaborate with non-psychiatric health care practitioners and so the language utilised in the MSE allows for effective communication between psychologists and other medical practitioners. As part of the Clinical Masters Programme in Psychology at UKZN, trainee psychologists are

expected to work in district health hospitals within the Discipline of Psychiatry once a week, and so their ability to understand and conduct a MSE forms a vital aspect of their training.

### **2.3 Cultural issues when conducting a MSE**

There has been some evidence (Lupton, 2012) that cultural conceptualizations of illness and wellness have been neglected due to the dominance of the biomedical model. This in turn has had far reaching implications both in assessing and treating illness and disease (both physical and mental). It is especially important to understand briefly the ways in which people from different cultures view mental illness, as this may greatly impact the outcome of a Mental Status Examination. First, it is important to understand what we mean by the term ‘culture’. For the purposes of this dissertation, the term ‘culture’ will be understood as defined by Helman (2007). Helman (2007, p. 2-3) views culture as a;

“set of guidelines (both explicit and implicit) which individuals inherit as members of a particular society, and which tells them how to view the world, how to experience it emotionally, and how to behave in it in relation to other people, to supernatural forces or gods, and to the natural environment. It also provides them with a way of transmitting these guidelines to the next generation – by the use of symbols, language, art and ritual.”

One important aspect that this definition provides when considering the mental status examination is that culture impacts the way that people view the world and how they experience it emotionally. This is best understood through the critique of the Western European idea of individual rationality, the *cogito ergo sum* (Mkhize, Ndimande-Hlongwa, Nyowe, Mtyende & Akintola, 2016). The authors go on to describe how this individualism is dominant in Western philosophy, sometimes referred to as ‘self-contained individualism’ or an atomistic view of the self, which acts as a container of psychological attributes and emotions. In this way, the self is seen to exist ‘out there’ and is considered separate from the others. Instead, the authors note that “Individualism is not the dominant mode of relating with others and one’s surroundings, in most of the world’s cultures” (Mkhize et al., 2016, p. 2). This includes many of the cultures found in South Africa, where expressions of self are not static and are a process of engaging with other human beings and the surrounding environment (Mkhize et al., 2016).



This experience and collectivist view of the world presents itself during the initial interview in a number of ways. One example is found within the isiZulu culture, specifically focusing on ancestral spirits, or ‘amadlozi’ (Edwards, Thwala, Mbele, Siyaya, Ndlazi & Magwaza, 2011, p. 132). According to work by Edwards et al (2011, p. 135), the researchers posited that ancestral consciousness was an essential feature of indigenous African spirituality. Ancestral consciousness was defined as: “various experiences, rites, customs and rituals in memory of personal, familial and communal ancestors, including animals, reptiles, ultimate sources, contexts, God and/or the Godhead and beyond” (Edwards, 2009; Edwards, Makunga, Thwala & Mbele, 2009) Ancestral consciousness then is essentially a way of being constantly connected to the ancestors, regardless of where one is or what they are doing. This goes so far even as to the way that an isiZulu person may speak English, which is often in plural form, reflecting their connectedness with the ancestors. For a trainee psychologist conducting a mental status examination, they are required to ask the individual about how they are feeling (affect inquired). A typical response from an isiZulu person to this question may be, “We are fine”. This response could potentially raise some discrepancies for the trainee, as the person’s response could indicate the presence of a collective experience which may have implications on the assessment of perceptual disturbances (not Dissociative Identity Disorder) as the client’s perception of self is in relation to the connected perception with ‘others’. Dissociative Identity Disorder is described as multiple versions of the self which the patient is unable to differentiate, or the presence of auditory hallucinations (associated with Psychotic Disorders). This makes the job for the trainee psychologist even more complex, as what is normally accepted as suggesting the presence of a major pathology may not be the same in other cultures.

Another example of the way in which mental illness may present in other cultures (specifically African cultures) is that of somatization, or experiencing psychological distress as a presentation of bodily symptoms. Swartz (2000, p. 8) describes how Western Biomedical culture is based on “the idea that there are some afflictions which are purely physical in nature and others which are psychological – on the idea that it is possible to conceive of mental and physical states as separate”. It is this model which greatly influences how psychology is practiced across the world, despite the inclusion of Somatization Disorder in the DSM-5. Swartz goes on to say that African cultures typically do not share this idea of the mind/body split, and so many psychological illnesses are experienced in the body. Again, this makes the mental status examination

increasingly difficult for the trainee psychologist to apply to people of other cultures, as the information elicited during this examination may not be entirely accurate of the individual's mental state, or it may be misinterpreted by the trainee psychologist.

## **2.4 The initial interview**

“Clinical interviewing is little more than helping people talk about themselves, which most people love to do” (Morrison, 2014, p. 1). Taken further than that, the initial interview that psychologists facilitate involves more than just clients talking about themselves. Instead, this interview involves asking clients to reveal something about their feelings and personal lives. Skovholt (2012) utilises a metaphor of a therapist wading into the anxiety and fear, despair and hopelessness, anger and rage of the client and standing in that pool with the qualities of fortitude, patience and serenity. Although a striking image, being able to do that effectively as a trainee psychologist is incredibly daunting and yet it is an ability that most trainees need to develop quickly and efficiently.

Skovholt (2012) goes on to say that the student experience of the initial interview is similar to the sudden onrush of water, rocks and rapids; which all demand instantaneous understanding and reaction. Often, trainee psychologists end up feeling very confused and unsure of what it is that they are actually doing, fearful that they may harm their clients instead of hear them. However, the main focus of the initial interview is to gather as much relevant and accurate information about the client as possible in the shortest period of time, all the while developing a working alliance with the client (Morrison, 2014). As mentioned previously the initial interview is made up of various aspects, namely; free speech, history taking and lastly the MSE. Although the focus of this dissertation is on the Mental Status Examination, it is still important to understand the other aspects of the initial interview as they provide the context in which the MSE occurs. Morrison (2014) describes free speech as the time when the client states their chief complaint, or their reason for seeking treatment. During this time the trainee psychologist is taught to actively listen to what the client is saying, enabling the client to tell their story without interrupting them and taking the attention away from them. The next section of the initial interview as outlined by Morrison (2014) is that of history taking, which involves the trainee psychologist asking the client about different parts of their life. Trainee psychologists training at the UKZN Masters programme are taught to include elements of social functioning, family history (as well as the

family's mental history), medical history, personal history, substance use history, sexual history, religious history, occupational history, educational history, relationship history and legal history. It can be seen that most of the interview should be spent gaining as much understanding as possible about the client in the context of their lives. The last part of the initial interview is the Mental Status Examination, although, as previously mentioned, observation should be taking place from the moment the trainee meets the client.

## **2.5 Academic Training**

Psychological training has been shifting towards competency-based assessment and training in the last few years (Baillie, Proudfoot, Knight, Peters, Sweller, Schwartz, & Pachana, 2011; Pachana, Sofronoff, Scott & Helmes, 2011). Psychology education and training programmes have begun to focus on questions such as, 'what does a competent professional look like and how should this competence be taught and assessed?' (Pachana et al., 2011). Falender & Shafranske (2007) state that competence is central to psychology as a profession, and that competence-based education can be used to identify the knowledge, skills and values that are used to form a clinical competency. Although a thorough discussion on competency-based assessed is beyond the scope of this study, the reader is referred to the American Psychological Association's seminal work on competence in professional psychology (American Psychological Association, 2006).

Before looking at the need for competency-based assessment and training the definitions of *competence* and *competency* need to be explored, as they have often been used interchangeably in the literature and resulted in confusion (Khan & Ramachandran, 2012). A commonly cited definition of *competence* comes from Epstein & Hundert (2002, p. 226), which was developed for the medical field; "Professional competence is the habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice for the benefit of the individual and the community being served." Stevens, Hyde, Knight, Shires & Alexander (2015) note that within the health-related field, *competence* relates to an individual's professional skills across various domains such as assessment, diagnosis, intervention and communication. *Competency*, on the other hand, is described as the particular skills that are found in these domains such as the use of specific tests, utilising evidenced-based interventions, building rapport with the client etc (Khan & Ramachandran,

2012). It is within the realm of *competency* then, that the use of the Mental Status Examination would be found. Stevens et al. (2015) further state that obtaining and maintaining competence should be a professional objective for all psychologists. In order to ‘obtain’ competency in the use of the MSE, the training that trainee psychologists receive in this area is incredibly important.

## **2.6 Psychology Training in the South African Context**

Training programmes for psychology in the South African context have recently been called to question in the literature (Pillay, Ahmed & Bawa, 2013; Pillay & Kramers-Olen, 2014; Kagee & Lund, 2012; Chitindingu & Mkhize, 2016). Much of the focus in the literature surrounding psychological training in South Africa has been driven to engage with possibilities for transformation (Pillay, Ahmed & Bawa, 2013). This notion stems from the history of Psychology in South Africa where psychology as a discipline was tied to the socio-political climate of the country and, as Pillay & Kramers-Olen (2012, p. 364) state, “It willingly colluded with apartheid policies regarding, among others, student selection, employment conditions, work areas, and service provision.” Similar to this, Ahmed & Pillay (2004) suggested that professional psychology training needed to realign their training goals and strategies to meet the needs of the South African context.

Despite the conflicted background of psychological training in South Africa, these training programmes have proven to be an excellent benchmark for developing professional training, and there are many significant strengths to be found in existing programmes across the country. It is imperative then, that in the face of continued growth and transformation, assessment of the significant shortcomings and failures of these programmes need to be taken into account if they are to be improved (Pillay, Ahmed & Bawa, 2013).

## **2.7 Conclusion**

The MSE is an interview screening evaluation of all the important areas of a client’s emotional and cognitive functioning (Daniel & Gurczynski, 2010). It can be seen that the MSE is an important psychometric tool to be used by the trainee psychologist as it provides the necessary data for formulating a psychiatric diagnosis or to develop a working hypothesis regarding a diagnosis. Mastery over the MSE is necessary as it is the primary means with which the trainee

will assess any new clients, which in turn may have serious consequences depending on the presenting problem of the client. Subtle elements such as observation are more difficult to master, and yet are all the more important. The data obtained from the MSE is given meaning when understood in the context of a thorough psychosocial and psychiatric history (Daniel & Gurczynski, 2010). This is where competency in the use of the MSE is important for all trainee psychologists to obtain, as the MSE becomes a staple assessment which they will use on a daily basis when working with clients.

Cultural considerations are important to take into account as culture influences the way people understand one another, or make sense of what is considered 'normal' and 'abnormal' behaviour. In a multi-cultural context such as South Africa, trainee psychologists need to consistently take into account the culture of their clients in order to fully understand them, being careful not to assume anything. It is also important for the trainees to understand how mental illness can present itself in other cultures (Swartz, 2000).

In conclusion, it is imperative that training institutions across South Africa are reflective in their teaching programmes in order to improve upon the many significant strengths that they already display. As the Mental Status Examination is a crucial tool to be used by psychologists, an improvement in how they are taught would be a good step towards the transformation which Pillay, Ahmed & Bawa (2013) have called for in the literature. A detailed exploration of trainee psychologist's experiences of challenges encountered when administering the MSE, would add insights to inform current and future professional training in the South African context. Research in this area would allow for an improvement of the training which trainee psychologists receive in relation to the Mental Status Examination at the University of KwaZulu-Natal during their Master's year.

# CHAPTER THREE

## *THEORETICAL FRAMEWORK*

### *3.1 Phenomenological Framework:*

The Phenomenological Approach is described as “the study of phenomena—in other words, of the world as it appears to experiencing and acting human beings” (Brinkmann, Jacobsen & Kristiansen, 2014, p. 22). The experience of human beings is thus the core focus of the phenomenological approach. The development of this approach was greatly influenced by Martin Heidegger and his work on existential philosophy, which places great emphasis on the very core of human existence. The Phenomenological paradigm can thus be considered a descriptive philosophy, as Brinkmann, Jacobsen & Kristiansen (2014) note, which utilizes the technique of reduction. Reduction is defined as “suspending one’s own judgement as to the existence or nonexistence of the content of an experience” (Brinkmann, Jacobsen & Kristiansen, 2014, p. 23). What this means is that it is not important whether or not the subject’s experience occurs and why, but instead the focus is placed on what the actual experience is and how it affects the subject. The subject’s experience is seen as an important phenomenological reality.

### *3.2 Interpersonal Process Recall (IPR)*

The ability to obtain a deep understanding of participant’s subjective experiences is not always easy and is made more difficult as when relying on the recall and memory of the participant. Larsen, Flesaker, & Stege (2008) state that accessing in-the-moment experiences of specific professional interactions (specifically counselling settings) has proved an obstacle for researchers to date. That is where the importance of the IPR method was necessary for this study, which relied on the recall and memory of specific client-therapist interactions.

IPR is defined by Larsen, Flesaker, & Stege (2008, p.19) as “a qualitative interview approach designed to access client and caregiver experiences as close to the moment of interaction as possible”. This method involves the participant choosing a relevant video-recording of an interaction, bringing it to the research interview, and then reviewing the recording together with the research interviewer. As the recording unfolds, the interviewer will ask the participant to comment on the interactions, focusing on the participant’s thoughts and feelings as they occurred during the interview with their client. Larsen, Flesaker, & Stege (2008) note how IPR is

particularly useful when accessing individuals' conscious yet unspoken experiences that occurred during the time of the recorded interview. This method of research was particularly useful for this study as it focused around the client-therapist interaction during the Mental Status Examination.

### ***3.3 Critical Incidents***

During the course of training, trainee psychologists undergo many changes as they develop more understanding derived from both coursework and the experience of conducting therapy. It is important thus to focus on those experiences which influence trainee development. These experiences, commonly referred to in the literature as *Critical Incidents*, are useful to use in order to understand specific interactions. Furr & Carroll (2003, p.483) define a critical incident as “a positive or negative experience recognized by the student as significant because of its influence on the student’s development as a counsellor”. Similarly Howard, Inman, & Altman (2006, p. 88) define critical incidents as “significant learning moments, turning points, or moments of realization that were identified by the trainees as making a significant contribution to their professional growth”. Potential critical incidents mentioned by Furr & Carroll (2003) may include developing a treatment plan, receiving support from a supervisor, countertransference and unfamiliar experiences for trainees.

Heppner and Roehlke (1984) note that a number of major categories of Critical Incidents have been found to impact on novice counsellor supervisees, namely; described self-awareness, professional development, competency and personal issues. It was also found that supervisees with varying levels of training were found to experience more self-awareness critical incidents (Heppner & Roehlke, 1984).

Howard, Inman & Altman (2006) propose that a phenomenological approach is well suited to exploring critical incidents in more depth as the qualitative data may come from various sources (such as the interview data and observations). Thus a constructivist approach may provide a better understanding of participant’s subjective experiences when it comes to discussing trainees’ experiences of conducting the Mental Status Examination and was thus a good fit for this study.

### ***3.4 Developmental Model of Training***

An important developmental model utilised in training is the Skovholt & Ronnestad Model (1992) (*see appendix 3*). The model was developed by Skovholt & Ronnestad (1992) following a study on 100 therapists and counsellors who ranged from being in their first year of graduate school to 40 years following their graduation as psychologists or counsellors. Themes were drawn out of the interviews and grouped into the following eight categories which would make up the final model: Definition and time period (the stage of training or career that a participant was in), central task, predominant affect, predominant sources of influence, role and working style, conceptual ideas, learning process and measures of effectiveness and satisfaction (Skovholt & Ronnestad, 1992).

This model is concerned with 8 steps that a trainee psychologist takes in their development as a therapist, beginning with the conventional stage (the many years before an individual undergoes training) and ending with the integrity stage (where the individual nears the end of their career and begins to prepare for retirement). Each of these stages is crucial in the development of the trainee and impacts greatly on their career as a psychologist. Although this model looks at trainee development throughout the lifespan, for the purpose of the current study, stage 2 (transition to professional training) was deemed as the appropriate developmental stage to conceptualize the data (Skovholt & Ronnestad, 1992).

The first stage, known as the ‘conventional stage’, consists of the many years before an individual undergoes any formal psychological training. They rely on what they know from experiences in their own life and they predominantly utilise sympathy when interacting with others. Their conceptual ideas are formed through common sense and the learning process is purely experiential. The second stage mentioned by Skovholt & Ronnestad (1992) is known as the ‘transition to professional training’, the level at which this study focused on. It is at this stage that trainee’s begin to transition to professional training (Skovholt & Ronnestad). The central task at this stage is for trainees to “Assimilate information from many sources and apply it in practice” (Skovholt & Ronnestad, 1992, p. 508). Coupled with this, the learning process utilizes cognitive processing and introspection (Skovholt & Ronnestad, 1992). This was important to consider as these are the processes that trainees underwent during the period of this study.



The third stage is that of the 'imitation of experts' stage. This occurs during the training and the central task outlined by Skovholt & Ronnestad (1992) is to simply imitate and learn from experts in the field. This occurs most notably throughout supervision, where the trainee is exposed to a range of conceptual ideas and techniques. The learning style described by Skovholt & Ronnestad (1992) at this stage is that of imitation, introspection and cognitive processing. The fourth stage, known as the 'conditional autonomy' stage, begins during the internship phase of the training and may last anywhere up to 2 years after the internship ends. The central task here is focused on functioning as a professional where the trainee has now gained more confidence in their role as a psychologist, drawing their influences from supervisors, clients, theories, peers and their personal life (Skovholt & Ronnestad, 1992). The beginnings of mastery over conceptual ideas and techniques begin at this stage and the trainee continues to learn through imitation (whilst becoming more comfortable with their own style), introspection and cognitive processing.

The fifth stage, known as 'exploration', occurs following graduation where the trainee psychologist is no longer considered a trainee. At this stage they may seek new work or fields of work which comes with increased confidence and anxiety. The central task becomes that of exploration. It is at this stage where, according to Skovholt & Ronnestad (1992), the individual begins to truly create their own professional style. Reflection is the primary mode of learning at this stage. The sixth stage is described as the 'integration' stage. The central task here is for the individual to develop authenticity, with their conceptual ideas becoming more personalized and individualized. The style of learning here is up to the individual to decide, whether it be through reflection, introspection or cognitive processing to name but a few.

The 'individuation' stage is the seventh stage of this model. Skovholt & Ronnestad (1992), state that this stage lasts for the majority of the individual's career which is anywhere from 10 to 30 years. The central task at this stage is focused on developing deeper authenticity, where the individual moves into what Skovholt & Ronnestad (1992) call a 'professional elder'. It is at this stage where conceptual ideas are personalized and individualized. The eighth and final stage of Skovholt & Ronnestad's (1992) model of therapist development is known as the 'integrity' stage. Here the central task shifts on to being oneself and in order to prepare for retirement. This stage is predominantly concerned with the individual accepting the ending of their career as a

psychologist, where they continue to learn through their own personally chosen methods and they continue to function as a professional elder.

As mentioned previously, this study focused on the second stage of the model, known as the 'transition to professional training'. It was at this stage in which the trainees of this study found themselves. The central task was focused on assimilating information from many different sources and applying it in practice, which occurred throughout the training year. Many of the trainees may have felt enthusiastic about making it to this level of training, and at the same time they may have felt insecure and anxious about whether or not they have what it takes to be a psychologist. As Skovholt & Ronnestad (1992) state, trainees may feel overwhelmed at the depth and scope of the many different sources of information which they will be required to take in and process. In turn, the trainees may have found themselves uncertain in their role as they struggled to fit theory into practice. The learning process at this stage was primarily through cognitive processing and introspection. Finally, the measurement of effectiveness and satisfaction was found through supervisory reactions and through client improvement.

# CHAPTER FOUR

## *RESEARCH METHODOLOGY*

### **4.1 Introduction**

The research attempted to explore the potential dynamics of challenges faced by trainee psychologists when conducting a mental status examination with adult clients. There are limited studies that have reflected on Professional Psychology (Clinical/Counselling) trainees' experiences of administering a Mental State Examination. This study highlighted the experiences of a specific sample of trainees; in order to inform further potential training needs that arose from the data.

The research design for this study was that of a qualitative approach. This type of design is often used to explore, describe, or explain social phenomenon (Brinkmann, Jacobsen & Kristiansen, 2014). The research was exploratory in nature. As such, the researcher attempted to understand the subjective experience of the participants without influencing the participants' experiences. Exploratory research has a twofold purpose of 1) permitting the researcher to observe the phenomena and 2) provide meaning and insight into a given situation.

Although trainee psychologists go through intensive training during their Masters year, they may still be faced with overwhelming anxiety when engaging in professional contact with actual clients. The Mental Status examination, due to its complexity (assessing different domains of mental health states) and its dependence on clinical judgement (content and observation), can be potentially challenging for novice therapists to administer. Previous studies (Rubenstein, Niccolini & Zara, 1979; Pohl, Lewis, Niccolini & Rubenstein, 1982; Birndorf & Kaye, 2002; Madson, 2011) have highlighted the complexities regarding skills development of health care practitioners. A common finding observed by these studies was the influence and impact of anxiety when working with actual clients. This study isolated a specific aspect of the training experience (i.e. Mental State Examination), with some evidence suggesting that this task has been difficult to apply post-training.

The training programme consists of both theoretical and practice based components. At least 60% of the programme involves practice based teaching (simulation and with clients) using clinical examinations and assessments. This leaves the window open for many challenges to be

faced when conducting the MSE, as it is not always a major focus of the initial interview. The existing body of literature has focussed on many aspects of mental health care practitioner training (Pohl, et al., 1982) with very little attention given to trainees experiences in the area of clinical skills practice. The current research study attempted to explore how trainees experience their application of the MSE when conducting an assessment of an adult client.

#### **4.2 Objectives**

- 1) To explore the experiences of trainee psychologists who have conducted the MSE with an adult client.
- 2) To identify trainees' appraisal of difficulties they experienced conducting the MSE.
- 3) To explore whether trainees perceived a shift in the therapeutic relationship following the administration of the MSE

#### **4.3 Research Questions**

- 1) What were trainee's thoughts and experiences around conducting the MSE?
- 2) What informed trainees' appraisal of difficulties whilst conducting the MSE?
- 3) How would a trainee's perception of practitioner/patient dynamics influence the way they administer the MSE?

#### **4.4 Sample Description and Motivation**

For the purposes of this research a non-probability sampling method was used. This entails that the participants were not chosen using a method of randomness, where each individual had an equal opportunity of being selected. Instead, for the purposes of this research, a purposive convenience sample was essential as it relied entirely on the availability of the trainee psychologists in the Master's program at UKZN as well as their willingness to participate. Purposive sampling is appropriate, as described by Ruane (2016), when the researcher has specialized knowledge or insight in order to select the elements of the sample. It is possible; Ruane (2016) goes on to note, that this method of sampling cannot be assumed to produce representative samples and so it results in poor generalizability.

#### **4.5 Inclusion Criteria**

Eight participants were selected on the basis of the following criteria:

- 1) They must be trainee psychologists in either the counselling or clinical field;
- 2) must be a trainee at a postgraduate level enrolled in the UKZN Psychology Masters Programme;
- 3) must have completed at least one clinical interview in which they administered a Mental Status Examination with an adult client.

The participants were selected regardless of gender, age, race, theoretical orientation and marital status, with the intention of acquiring a heterogeneous sample.

#### **4.6 Study Sample**

A sample of 8 participants, making up the study sample, was used for research purposes. The study sample comprised of 2 male and 6 female trainee psychologists who verbally identified as having difficulties with conducting the Mental Status Examination. The study sample was drawn from the identified study population drawn from the target population.

#### **4.7 Trustworthiness**

In order to ensure trustworthiness, Morrow's (2005) qualitative research guidelines have been followed, and the following aspects will be targeted:

- 1) **Credibility** – information obtained shall not be altered or amended nor will any information be created.
- 2) **Reduction of bias** – the very best information will be attempted to be obtained and measures will be implemented to reduce information bias. This will be expanded below:
- 3) **Information bias** – the questions in the interview will be concise and clear to prevent any confusion, ambiguity or misunderstandings. Clear instructions will be provided to ensure that participants fully understand what is required of them. Furthermore, the interview will be conducted on a personal level thus they may ask the researcher if they require clarification. Overlapping questions will be avoided and only relevant questions pertinent to the study shall be asked.

#### **Limitations within trustworthiness:**

- 1) **Selection bias** – due to the specific inclusion criteria, selection bias will unfortunately be introduced into this study. By doing a sample of convenience rather than a random

sample, selection bias will occur as not all clients will be eligible to participate, however the selection criteria is the most feasible for this particular study.

- 2) Target Population** - This study focuses on trainee psychologists currently registered at the University of KwaZulu-Natal in the Clinical or Counselling Psychology Masters Programme and as such the generalizability of the results to trainee psychologists attending other universities may not be applicable. Furthermore, interviews will be conducted in English and as such, individuals who do not speak English will be excluded from the study.

#### **4.8 Measurement Instrument**

This study utilised semi-structured interviews as the chosen measurement instrument. The interviews were guided by an interview schedule with open-ended questions and follow-up probes. Semi-structured interviews consisted of a number of key questions that helped to define the areas investigated in the study, but also allowed the interviewer and interviewee to explore ideas in great detail (Neuman, 2011). According to Neuman (2011), a semi-structured interview comprises of a standardized series of questions that because of their flexibility, allow for the researcher to ask follow up questions based on the response given.

The instrument was developed by the researcher, utilising the research objectives and questions in conjunction with the Stage Model described by Skovholt & Ronnestad (1992) in order to generate questions that would facilitate discussion around the experience of the participant in administering the Mental Status Examination with an adult client.

*(see appendix 1 for measurement instrument)*

#### **4.9 Data Collection**

All interviews with the participants were recorded using an audio recorder and the interviews were transcribed verbatim in English. The data collection process began with the interview where the researcher and participant viewed the relevant section for the research purpose. Using the IPR method, the relevant section of a recording was marked and viewed. This method involved the participant choosing a relevant video-recording of their trainee clinical interactions,

which was then brought to the research interview, and then together the participant and research interviewer reviewed the video-recording. As the recording unfolded, the interviewer asked the participant to comment on the interactions, focusing on the participant's thoughts and feelings as they occurred during the interview with their client. The semi-structured interview was used in conjunction with the video-recording to gather information from the participant/trainee. The participant was then required to reflect on how they experienced the initial interview as well as to share their feelings about any critical incidents, self-talk and other thoughts and emotions that may have arisen during the interview process.

The form of the semi-structured interview was intended to provide some guiding questions but also to stimulate the natural flow of conversation, allowing the interviewer some freedom to explore any relevant issues. The interview allowed the participant the opportunity to reflect on their subjective experience as openly and naturally as possible, which was in line with the phenomenological framework adopted by this study. The interview also aimed to collect the demographic data of the participants and to explore the challenges experienced during the initial interview whilst conducting the Mental Status Examination. The use of the Critical Incident conceptualization assisted in the thematic analysis of the data.

The transcription were then analysed thematically in order to identify commonalities and variances among the responses of participants.

#### **4.10 Procedure**

Permission was sought from the Director of the Centre for Applied Psychology at the University of KwaZulu-Natal. Each participant was contacted through the use of purposive sampling and selected based on the inclusion criteria, as well as on their willingness to participate in the study. Participants were made aware of the objectives of the study as well as of any relevant ethical considerations that appeared throughout the research process. Anonymity was maintained through the use of pseudonyms for each participant, and their descriptive information was kept confidential. Participants were made aware that they were allowed to cease their participation in the study at any point, without facing any prejudice from the researcher. Permission to audio record the interviews was sought from the participants prior to conducting the interviews.

Informed consent forms were given to the participants before they took part in the study which included information about the researcher, the purpose and the importance of the proposed study. Both the researcher's and supervisor's contact details were displayed on the form. Details such as the amount of time it could take to complete the interview and any confidentiality issues were also mentioned on the form. Once the participants had signed the informed consent forms, they were asked to bring the video recorded session of their first ever interview with an adult client to their interview as per the Interpersonal Process Recall (IPR) method. The interviews were audio-recorded (see appendix 2 – consent for audio recording) and later transcribed preceding the thematic analysis.

The interviews took place at the UKZN Centre for Applied Psychology Clinic on the Howard College Campus. The interviews varied in length from 30 to 50 minutes.

#### **4.11 Data Analysis**

This design used the IPR (Interpersonal Process Recall) process, coupled with a semi-structured interview in order to gain rich information from participants. Data analysis was based on that of Thematic Analysis. The decision to use Thematic Analysis was made as after transcribing, reading and starting to use Interpretive Phenomenological Analysis, it was clear that the data leant itself towards a thematic approach as no new phenomena was being uncovered from the data.

As the research operated from an interpretive paradigm, a basic thematic analysis was used. This study sought to gain insight into people's subjective experiences and so this method of analysis was most appropriate. The data gathered from the study was analysed using thematic analysis, in order to group common themes that arose. The transcripts were studied in great detail and notes were made during the process. The data was categorised according to the common themes as they emerged with a focus on issues such as personal challenges, training, client characteristics and culture and language dynamics.

Data analysis was based on thematic analysis using the following steps outlined by Terre Blanche, Durrheim & Painter (2006)



### **1) Familiarisation and immersion:**

Once the data is collected it requires involvement with the data and the development of ideas (Terre Blanche, Durrheim & Painter, 2006). It is necessary to read the transcripts of the interviews a number of times before knowing where to find information and how the data may support any interpretations (Terre Blanche, Durrheim & Painter, 2006).

### **2) Inducing themes:**

Through looking at the data, themes and ideas become apparent, following a "bottom-up approach" (Terre Blanche, Durrheim & Painter, 2006). This step requires more than simply summarising the themes and requires a greater understanding of processes, tensions, contradictions and functions underlying the data (Terre Blanche, Durrheim & Painter, 2006).

### **3) Coding:**

This process involves differentiating between themes and sorting information into categories (Terre Blanche, Durrheim & Painter, 2006). During this process different sections of the data are marked in order to sift through information that is relevant to the research and that which is not (Terre Blanche, Durrheim & Painter, 2006).

### **4) Elaboration:**

During this stage the themes are explored deeply in order for the researcher to gain new understandings of the data or to find deeper meanings that may emerge from the data in order to develop themes (Terre Blanche, Durrheim & Painter, 2006).

### **5) Interpretation and checking:**

The final stage involves the researcher reflecting on all themes and sub-themes that have emerged, as well as providing an understanding and context of the data (Terre Blanche, Durrheim & Painter, 2006).

The data analysis will be organized based on the method utilised by Ose (2016), through the use of Microsoft Word and Microsoft Excel to organise and structure the data. Following the 5 steps of Thematic Analysis, the themes were identified by first identifying descriptive codes; these were then developed into sub-theme codes that related to the central code. (*see appendix 4*)

#### **4.12 Ethical Considerations**

Ethical clearance for the study was sought from the Postgraduate Research Ethics Committee (Applied Human Sciences) at the University of KwaZulu-Natal. The ethical clearance number for the study is as follows: HSS/0683/017M (*see appendix 2*)

Informed consent was obtained from each participant and each participant was made aware of their right to withdraw from the study at any stage without prejudice (*see appendix 2*). Permission to audio record the interview was sought from each participant before the interview took place. Before the interviews were conducted, permission was obtained from the gatekeeper on behalf of the participants (*see appendix 2*).

Consent to access the clinical interview was obtained from the trainee and supervisor. Client consent was obtained prior to the trainee's first consultation. Therefore, viewing the recordings of each participant and their client with the IPR method does not impinge on confidentiality of the client as no details will be recorded apart from age, gender and historical population group.

#### **4.13 Self-reflection**

It is important to consider the stance of the researcher throughout the process of conducting the research. The interviewer as the research instrument was specifically chosen as it afforded the researcher a unique perspective on being a trainee psychologist and having to learn and use a clinical assessment such as the mental status examination. The introduction of bias in the study is a prominent factor to consider as the researcher was a part of the same training programme as the participants of the study. As a result of this, the researcher too conducted the MSE and was exposed to the same training as the participants. This may have influenced the analysis and outcomes of the study, although constant reflection was utilized in order to minimize the possibility of bias. In addition to this, the focus was placed on the experiences of the participants, and care was taken to not focus on the feelings of the researcher. Even so, bias may have still influenced the outcomes of the study and this needs to be taken into account when interpreting the results.

## CHAPTER FIVE

### RESULTS

The results of the semi-structured interviews will be documented below. The data has been organized according to the themes that emerged from the data collection process. Specific excerpts from the data are presented in this chapter for each participant in accordance with the major themes derived from the analysis. All of the themes emerged from the data a posteriori. The first thematic area, *transition from theory into practice (student to clinician)* related to participants' subjective experiences regarding the practice component of their professional training. The second area, *process issues in administering the MSE*, illustrates participants' experiences of administering the MSE. The third area looks at the impact of *client characteristics*, including the age, gender and race of the client, and how, if at all, that impacts on the trainee psychologists' ability to conduct the MSE. The fourth and last thematic area, *culture and language* are explored, which considers whether cultural similarities or differences, as well as language, has any effect on the trainee's ability to understand and conduct the MSE.

Socio-demographic characteristics of the study participants are presented in Table 1.

**Table 1: Demographics**

Participants	Registration Classification	Age of Participant	Population of Participant	Population of Client	Gender of Participant	Gender of Client
INT001	Clinical	25	White	Black	Female	Female
INT002	Clinical	39	White	White	Male	Male
INT003	Clinical	22	Indian	White	Female	Female
INT004	Counselling	32	Black	White	Female	Female
INT005	Counselling	25	Black	Black	Female	Female
INT006	Clinical	26	Black	Black	Female	Female
INT007	Clinical	25	Black	Black	Female	Male
INT008	Counselling	23	Black	Black	Male	Female

*Table 1*

A majority of the study participants were female (N=6), with only two males forming a part of the study. The ages of the study participants ranged from 23 years old to 39 years old, with a mean age of 27 years old.

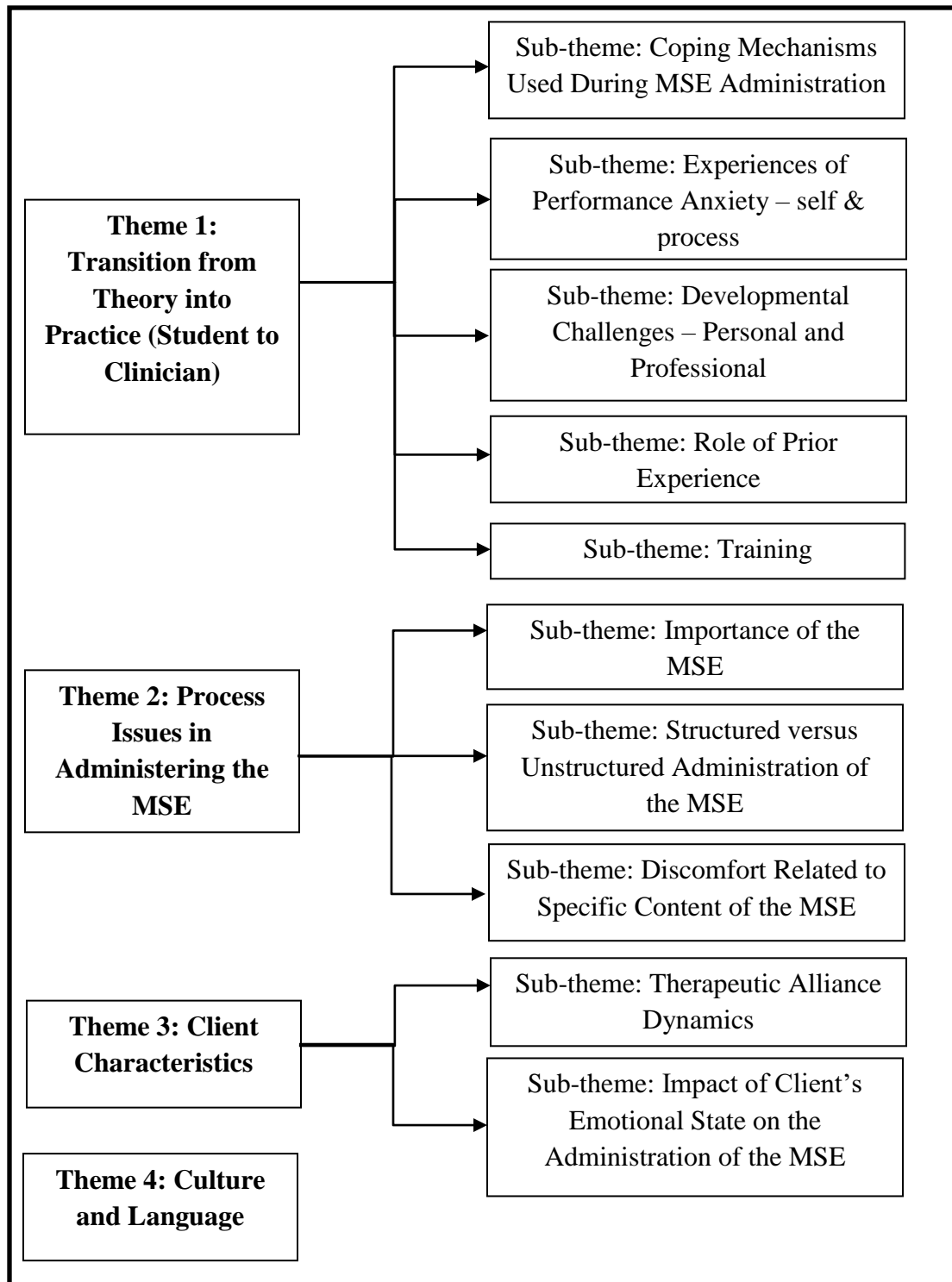


Figure 1. Figure illustrating the development of themes and sub-themes.

## 5.1 TRANSITION FROM THEORY INTO PRACTICE (STUDENT TO CLINICIAN)

Almost all of the trainees (N=7) described how they felt overwhelmed throughout their experience as a developing clinician. Large amounts of coursework and personal anxieties relating to seeing people with real problems were some of the challenges described by the trainees.

*Umm (laughs), it's been really hectic [masters course], umm, very interesting, I think that there are lots of challenges that come along the way, just personal challenges too. Umm, it's a very strange sort of process because you're learning a whole lot of theory and you start taking clients, but I think the biggest thing that gets worked on in masters is really like your own strengths and weaknesses, and the process kind of just brings out things, you know, inside of you that you didn't really necessarily know about or you, just you know things that you have to kind of face and work through so that you can be effective.*

[INT001, 25 years old, Female]

***I: So tell me how that's been for you? What has it been like?***

*Wow, okay from the beginning it was quite nerve-wracking, umm it was one of the things I had anticipated the most like, part of being a masters student actually seeing people with real problems unlike undergrad where, you know it was also abstract and theory and stuff. So this year was about applying it so I was looking forward to that; okay because it would make me feel like I'm doing something finally at the same time I was quite anxious about it as well.*

[INT005, 25 years old, Female]

*Overwhelming. It's just too- it's just so much stuff to do and I feel like there's so little time, sometimes I feel like I don't know what I'm doing and you know, I question myself if I'm in the right direction (laughs).*

[INT006, 26 years old, Female]

In contrast to this, one of the trainees felt that the clinical psychology masters course did not meet their expectations in terms of being prepared and confident in their role as a developing clinician.

*In terms of this particular process of this course, um, I felt, that it's been rushed, and perhaps not demanding enough, to be perfectly honest, I felt that there was a lot of hype about how intense the course is and it would be... and it has been fairly intense, but in terms of like, actual, hands- on experience, from, in therapeutic, clinical kind of role, I feel a little unprepared to go out into the big wide world (laughs).*

[INT002, 39 years old, Male]

At all levels, the trainees described how the master's course had allowed them to learn more about themselves

*Umm, lot of anxieties in the beginning, umm, not knowing what I'm doing, scared, you know I'm- it's all about self-evaluation in the beginning you know, and uhh, and competence, so you want to make sure you doing the right thing. You're going to be applying it, so, ya it was interesting and I'm learning as I- as I said in the beginning I'm learning a lot from the course and I'm learning a lot about myself.*

[INT008, 23 years old, Male]

### **5.1.1 Experiences of Performance Anxiety – Self and Process**

Throughout the course of the MSE, trainee's described how, at varying points, they experienced anxiety relating to their own competence, how the client perceived them, as well as their ability to conduct the MSE.

Some of the trainee's described how their experience or lack thereof, greatly contributed to their expression of anxiety whilst conducting the MSE, which was seen in the way they asked questions or through their body language.

*Yeah... Definitely. That anxious laugh there I mean- I guess, you know, this was the first one I'd done and I think on that point of anxious laughs, um, I've, I think there's some*

*value in the MSE in the sense that um, or one of the values in it for the client, I would imagine, is the feeling that, okay this guy knows what he's doing and he's just giving me some stuff that need- I need to do- and there's a sense of accomplishment, because he goes, I can remember all the 3 things, he could get the serial sevens-*

[INT002, 39 years old, Male]

Despite feeling anxious whilst conducting the MSE, a number of the trainee's described how they were motivated by their concern for the client, which in turn helped them to continue conducting the MSE.

*Yeah, it was quite some time back but, um what I do remember thinking is that um, I just assumed that a person would just say no, or they actually wouldn't take that much time in having to answer the question [hearing auditory hallucinations], but she sat and she thought about it and that made me then go back and think, 'okay is she gonna tell me the truth if she is actually having this, is she having this, is she going to lie to me or is she not having this, and if she's not having this then why is she not saying anything'. So as she was saying this I was thinking of a million different things and I didn't want her to see this, um, but and I felt uncomfortable when she mentioned that and then of course my defences, my default rather, is to just laugh.*

[INT003, 22 years old, Female]

One of the trainee's described how their own personal struggle with anxiety impacted on their ability to conduct the MSE.

*She's like the same age as I am and she has anxiety pro- problems, so that was like the presenting problem and I also like suffer from that. So it was quite challenging for me to, you know, to deal with that.*

[INT006, 26 years old, Female]

Furthermore, the wording of the questions in the MSE led to some of the trainees feeling anxious about their competence.

*Ummm, I felt that I was doing something wrong. Because why would the client not understand what I'm asking them? But now looking back retrospectively I understand that some of these questions sound, lack of a better word, crazy to the client you know, 'why are you asking me these things I'm here for something else'. But it's just the matter- it's just a matter of how do you ask them, because I was really nervous here so I- and you can see me laughing you know, giggling here and there, umm it was the nerves because I was just looking at this paper and I'm like, 'what do I ask next?' and at some point it moves from the MSE to us talking about how they feeling and then it goes back to the MSE so there's no structure at all.*

[INT007, 25 years old, Female]

### **5.1.2 Developmental Challenges – Personal and Professional**

The theme of personal challenges ran throughout each of the trainee's experience of the clinical/counselling psychology master's course. Trainee's provided a range of explanations to account for these challenges including learning about personal strengths and weaknesses, growing insight, personal experience with mental illness and conflicting roles in therapy.

*Umm, very interesting, I think that there's lots of challenges that come along the way, just personal challenges too. Umm, it's a very strange sort of process because you're learning a whole lot of theory and you start taking clients, but I think the biggest thing that gets worked on in masters is really like your own strengths and weaknesses, and the process kind of just brings out things, you know, inside of you that you didn't really necessarily know about or you, just you know things that you have to kind of face and work through so that you can be effective.*

[INT001, 25 years old, Female]

*Uhh, on a personal level, lots of things are happening on a personal level in terms of growing and in terms of level of insight, you know... reflection ya, so I think on a personal level there's a whole of things going on as well.*

[INT005, 25 years old, Female]



*And she has anxiety pro- problems, so that was like the presenting problem and I also like suffer from that. So it was quite challenging for me to, you know, to deal with that. Because I wanted her to get better but I'm not sure if it's for me or I was doing it to, you know.*

[INT006, 26 years old, Female]

### **5.1.3 Role of Prior Experience**

At all levels trainee's cited experience as being a key factor which either inhibited or improved upon their ability to conduct the MSE. Given that the study focused on the trainee's first attempt at conducting the MSE, many of the trainee's described how their lack of experience contributed to the eventual outcome.

*Uh, the first few questions, I guess, overall the experience has been okay. I've become more comfortable as I've actually conducted more MSE's. So I guess with practice and experience it has become much easier but still around those questions...*

[INT003, 22 years old, Female]

*Umm, sometimes I just feel it's- one needs to know like what- I think the more you do it repeatedly and continuously it actually helps, exposure and experience helps a person know what to actually do when you're doing an MSE and umm, ya.*

[INT004, 32 years old, Female]

Hospital placements aided some of the trainee's in helping them to gain more experience around conducting the MSE.

*When we went to some of the hospitals recently they gave us like sort of a print out of a basic MSE and I think maybe if we'd had something like that in the beginning it would have been helpful, I think it would have been very helpful.*

[INT001, 25 years old, Female]

*I have actually conducted a couple more to be fair, at the hospital, in a hospital setting and it's nothing really like what was happened in here. It was, there was a lot more,*

*interpretation. Time for interpretation based on other behaviours and responses by the client where I was able to make interpretations and didn't need to go through the tick-box exercise um, yeah.*

[INT002, 39 years old, Male]

Whilst some of the trainee's described how supervision aided them where they were able to rely on the experience of the supervisor.

*So, I think that was like a nervous smile because when she asked about that I did not know what to say because I was not sure whether we are supposed to... whether we, we are allowed to do that [prescribe medication]. So I needed to check with my supervisor before umm, doing all that and she also mentioned that, you know, I want to feel better, I want to- all this anxiety to go away so pills will help me to just, you know-*

[INT006, 26 years old, Female]

Retrospectively, one of the trainees's described how, at the end of the year, their ability to conduct the MSE had improved greatly with more experience.

*I think it has grown, umm it's like a developing experience, umm, I spoke to one of my colleagues not so long ago. I said that, 'you know when I conduct the MSE now, it's different, there's a different feel about it after what is it, 7 months into the programme now'. So you sort of know what you're looking for, you know, it's it's- easier to to- to- to remember some of the material you have to cover of the MSE as opposed to my very very first experience where I had a lot of information.*

[INT008, 23 years old, Male]

#### **5.1.4 Formal Training – Administering the MSE**

The aspect of training was frequently explored by the trainees as a factor which inhibited their ability to conduct the MSE. Transitioning from theoretical to practical application, confusion around the content covered in the MSE and a lack of initial practical demonstration were

discussed by the trainees as contributing to their difficulties in conducting the MSE. Supervision was also frequently discussed by trainees as a positive training factor.

*Umm well definitely the training, I mean first MSE, umm I think that when you are introduced to the MSE it's a bit overwhelming because you read like a whole chapter or something on the MSE and then you somehow supposed to put this into a format that you can remember and conduct with a client.*

[INT001, 25 years old, Female]

One trainee described the training programme as not including enough practical exposure.

*Personally I think we should've, there should've been more focus on not 25 hours, but 50 hours, and less focus on some of the other aspects. More supervision, more practical experience I think would have settled me a bit because I've only now had 2 clients strictly speaking. One assessment case, and, but that's just 2 clients and I'm reading other peoples cases, or hearing what other people are doing and think...*

[INT002, 39 years old, Male]

Whilst another trainee suggested a different method of teaching the MSE.

*Ya. Ya, so uhh we did a lot of role play of the MSE, but I think- I think I would have preferred something different. You know, perhaps if (Lecturer's name) was there giving us an example of how an MSE might look like, you know? But I think we had a short uhhh, session on what the MSE is about but in terms of applying it, I don't think he- I don't think he- he showed us how- how to, so we had to constantly look for questions, look for how to phrase questions that are important so, ya. It was- it was very, ya. I think- I think that's what was part of the difficulty that was facing me, because I looked for the questions myself. I looked for information myself, we were sharing information amongst ourselves as classmates on the things that were- that were significant, so information was all over the place. So- and then I had to, uhhh, I had to get my own MSE order in such a*

*way that is- that I think is most appropriate, so I'm not sure if- if- if it was a good enough MSE at the end of the day.*

[INT008, 23 years old, Male]

Supervision was almost exclusively described by the trainees to be helpful with regard to the practical element of the course, including the MSE.

*So Initially I struggled with that and of course the practical skills lacking there um, yeah but as it progressed and I spoke to my supervisor about it and she said well actually you just have to set boundaries and this is what we're going to have to do, so yeah.*

[INT003, 22 years old, Female]

#### **5.1.5 Coping Mechanisms used during administration of the MSE**

A range of different coping mechanisms were described by the trainees when they felt nervous or awkward. At times, the insecurities of the trainees came to the surface in the form of nervous laughter.

*Hmm. Um, I actually, in this case I wasn't, I wasn't, I initially thought I wasn't too concerned about it but I saw my discomfort level, when I'm uncomfortable rather I laugh or I think I said once, ugh you know these are routine questions and they might seem weird at times.*

[INT003, 22 years old, Female]

Whilst another trainee described how their non-verbal language was an attempt at managing their anxiety.

*Oh my word, it- it was (laughs), lack of a better word, horrible. (laughs) I was nervous, I was- I was very anxious. Uh uh, we'll see in the video I- I kept on you know, like grabbing my arm just to keep calm, I was playing with the pen and I think more than anything it was the, the nature of the case that made me anxious because it was my first case, I would have preferred if it was a child.*

[INT007, 25 years old, Female]

In one case, the trainee described how introducing the MSE questions as ‘weird’ helped them to cope with administering the MSE.

*Hmhm. Um, I actually, in this case I wasn't, I wasn't, I initially thought I wasn't too concerned about it but I saw my discomfort level, when I'm uncomfortable rather I laugh or I think I said once, ugh you know these are routine questions and they might seem weird at times and um, I remember stating that because I was at placements [Hospital placements] once this year and um, one of the people working in the department stated that if you're feeling as uncomfortable or weird then state it to the actual client that it might seem weird to you or it might not but um, just bear with me and answer the questions and so I felt it was necessary to say that at that point because I did feel that some of those questions are weird.*

[INT003, 22 years old, Female]

Supervision was used by another trainee as a form of coping.

*Umm, I think because of experience, you know, so you go to supervision and you could ask a lot of questions and we have diagnoses that you have to think about. So all of those things you start to, you know, form patterns in your head like, 'you know what perhaps I could get this information by- uhh oh ya, that was- that's what the MSE was about'. Then we start, you know, putting- putting things together and then ya, you sort of grow into it, you're like 'okay, perhaps this is what I should, this is what I should say', and then- and then- and then ya you become better at it. So you know I'm still- I still think there's room for improvement even though I feel much much better about the whole process today.*

[INT008, 23 years old, Male]

Finally, in one case, the trainee dealt with their anxiety through the use of a clipboard and the structured nature of the MSE questions.

*Yes it was my comfort zone. So every time I was anxious I would look down to just you know have a sort of, umm, assurance that you know everything's go- still going by the book.*

[INT008, 23 years old, Male]

## **5.2 PROCESS ISSUES IN ADMINISTERING THE MSE**

The trainees alluded to similar experiences when it came to engaging with the content covered by the Mental Status Examination. Common areas of attention regarding administering the MSE included: unstructured acquisition of information, benefits of using structured/directed questioning for content, timing and mode of eliciting specific information and lexicon difficulties (translation). Many of the trainees acknowledged the importance of conducting the MSE.

*Ya it's difficult to remember everything in the session because you can sort of see important things that are coming up sometimes and then you gotta try and remember that for the MSE. But I, I think it's a good thing that you do the MSE because you won't necessarily always find that stuff out in the interview until you ask those specific questions. I mean as it is it takes a long time to just get a full picture of the client and what they going through, but umm, I didn't find that it was really repetitive in this MSE. I think this MSE was helpful.*

[INT001, 25 years old, Female]

In some instances, the trainees (N=4) described the value of the MSE with regards to the flexibility of the questions.

*Umm, I think there- the interview I just let it flow with what she could give me so some of those things would come up and then I would... Ya. Go with them as they happened. For example, the vegetative symptoms I spoke to the- I spoke about them, also at the beginning of the session where she was telling me about herself and what she likes to do and she likes to spend a lot of time sleeping and all of that-*

[INT005, 25 years old, Female]

*Whereas when it was spaced out it was- it didn't even feel like I was going to be asking questions like for example, 'have you ever tried killing yourself?' It would have been very awkward to ask them in the sense of structure, 'yes, no', all of that, but when it came up in the interview it came up in a way that wasn't very much a direct question but related to things that she had a- is also saying so it was much easier.*

[INT005, 25 years old, Female]

Whilst others (N=3) felt that the structure of the MSE inhibited them in obtaining the necessary information from their clients.

*Do you see what I mean? I felt, I feel really uncomfortable now to go back to the structured MSE when she's speaking about something and I want to stay on that point and I want to continue speaking about the fact that she felt like she didn't have a support system and now she does, but what's going to happen tomorrow, and I wanted to continue with that but I couldn't because I had to go back to this MSE.*

[INT003, 22 years old, Female]

*Can you notice how elaborative she is, like she doesn't- I think that's one of the reasons where I just sort left it [the MSE] not completely done because she's very elaborative and she brings up certain issues that I felt they are more important to actually probe more on then than just to continue and asking umm, like your more structur- structured sort of- [questions].*

[INT004, 32 years old, Female]

At all levels, the trainees described how the wording of the questions utilised in the MSE became an obstacle for them. Explanations for the difficulty with the MSE questions ranged from feeling discomfort with asking the questions, feeling worried about how the questions would be received by the client or simply not knowing how to phrase the MSE content specific questions.

*Umm, not just with you know, my first adult client, in general conducting the MSE is very difficult. Umm it- it's not that the questions are difficult, but it's- it's how the, the client*

*or the patient receives those questions. Umm you'll notice in the video that uhh, my client laughs at some of the questions when I ask her about delusions and hallucinations. Uhh, it's- some of the questions are very uncomfortable for me to ask because it's like, "really you can see that there's nothing wrong with me".*

[INT007, 25 years old, Female]

Meanwhile, some of the trainees explored how the technical jargon used in the MSE and the lack of standardised questions made it more difficult for them to understand and differentiate between the questions.

*Umm, but it's- it's been very difficult no. Another difficult aspect of the MSE for me is the jargon, where you get uh for example umm, affect, where you get different jargon related to affect or to thought content, is it tangential, circumstantial- some of these terms actually seem similar.*

[INT007, 25 years old, Female]

Whilst others described how the lack of a formal translation of the MSE questions from English into isiZulu became a barrier in completing the MSE.

*Umm, a rephrasing the questions from a language perspective because the MSE that I had, like the- the- the- the questions they were written in English and this client could not speak English so I had to rephrase them and ask them in- in a Zulu way you know, so some things they sounded more strange.*

[INT005, 25 years old, Female]

*But I could, you know, as I'm looking at this I could remember the feeling that was in the session there that you know what, umm, there's some meanings lost here, umm in- in- in the questions that I'm asking. So ya if- if I could improve something here would be, you know, sort of linking uhh the English and isiZulu language so that my client can better understand what I'm talking about.*

[INT008, 23 years old, Male]



### **5.2.1 Importance of the MSE**

Despite the difficulties encountered whilst conducting the MSE, many of the trainees acknowledged the importance of having to conduct the MSE, or they acknowledged the importance of the information yielded in the MSE.

*Umm, ya I feel it's it's, MSE it's actually you know, important and it sort of the core of the whole first sort of an interview so it, because it helps one to actually understand the pres- how the person presented.*

[INT004, 32 years old, Female]

Although at times, the trainees struggled to find the balance between staying with their client and conducting the MSE.

*Yet again I- I wanted to stay with that but I kept on looking at the time, um, and thinking to myself, 'why do I need to continue with these questions?' And I know why I need to continue with them, um, from a theoretical perspective and logically I know why, um, but I just feel as though she wanted to talk a bit more about this.*

[INT003, 22 years old, Female]

Furthermore, difficulties regarding the timing and execution of the MSE was expressed in the following quote where one participant alluded to repositioning the MSE when conducting the initial interview.

*It almost should be at the beginning, thinking about it. It should be right in the beginning get that out the way, and then you, before you've even made an interpretation, so that they're also aware of it. I think the idea, you know I mentioned earlier that it's somehow condescending, um, it wouldn't be so if it were right in the beginning because it would be like when you go to a doctor and he just goes, 'Okay you're gonna...' - but then on the other hand if you, on the other hand a doctor doesn't start off with a physical examination, they start off with a, with a, 'What brought you here today?'*

[INT002, 39 years old, Male]

### ***5.2.2 Structured versus Unstructured Administration of the MSE***

The flexibility of the MSE questions yielded contrasting results amongst the trainees. Some felt that the MSE lent itself to being flexible throughout the session, whilst others felt that the MSE felt too structured and instead hindered them from gaining the information they needed.

The ability to ask the MSE questions throughout the clinical interview was cited as being a benefit of the flexible nature of the MSE.

*Um... I think that the, from my point I think there were certain aspects of it that I was able to integrate in so it didn't feel like a test, so for example when he talked about, he raised the thing about being involved in crime, uh sorry, litigation and stuff like that, that he sued some people and then I said, I brought up, I then kind of integrated it without, I think without him even being aware of me then alluding to the idea of has he been involved in crime. And then I... and then I, another time I think I said, I brought up this worry and I said does that ever cause you feelings of self-harm? Um, though it, by integrating it in such a way so that it's almost a seamless exercise, also maybe, waters it down somewhat because then he expects these series of questions and doesn't even notice they've been asked.*

[INT002, 39 years old, Male]

In another instance the structure led to feelings of comfort for the trainee, whilst at the same time led to perceived feelings of discomfort for the client.

*Yeah, and also weird because, you know, it's like you have this checklist now, 'if you have this, check, this no', and so it was- for the client I don't think... Yes I think for the client it was quite weird because you, if you can see there whenever I, you know, I write something she will kind of like want to see what am I writing there... Although I did explain that this is just to, you know, check your- your mental status now, but I didn't think she was comfortable whilst I was asking these questions.*

[INT006, 26 years old, Female]

Whilst others felt that the structure of the MSE greatly limited their ability to probe further to gain more information, and instead became about getting through the questions as a formality.

*So I'm not sure if it would be better kind of read off a script, 'boom Question 1, Question 2, Question 3', though that way there gives no time for his divulgence in his personal experience but rather its treated as such, as a test.*

[INT002, 39 years old, Male]

*I'm just repeating them again coz I've already had a- had them, ya, jotted down on my clipboard. So, ya, so it was, was about my clipboard, was very external to me you know as opposed to today where I feel different about the questions that I'm asking.*

[INT008, 23 years old, Male]

In some instances, the trainees felt uncomfortable to continue with the structured MSE questions.

*It felt awkward when i- when she started to sort of elaborate and also that I couldn't like go back now to sort of like- remember this was also my first umm, my first client and I couldn't like really go into the umm, intake sheet and say you know, hang on I want to ask this, this, and that so it was a little bit awkward in a way.*

[INT004, 32 years old, Female]

And in some situations, the trainees actually preferred having the structured MSE questions to follow.

*Yeah I think the structure. I think just having-, um, so what I did is I typed out the questions so I have this set thing that's typed out and um, the, the MSE as well is typed out so I guess...*

[INT003, 22 years old, Female]

The presentation of the client was described by one trainee to have impacted on how she conducted the MSE, making it more difficult to follow the structured questions.

*It helped me to ask certain questions but then I think when it becomes- I dunno whether it's my client and the presentation or what, umm, because comparing this with my other interview I found it helpful because my patient then was more, much stable, much content. Then I was able to go through everything like in a structured- structured sort of style, but then there she was emotional and not really content which made it even harder for me to actually go through the, the the, the mental state.*

[INT004, 32 years old, Female]

In some cases, the wording of the questions led the trainees to feel as if they were being condescending or patronising towards their clients.

*I think the, the awkwardness um, of asking somebody something which I already kind of know the answer to, umm, and almost feeling like I'm patronising them. Umm, which I didn't want to therefore cause a um... cause any kind of umm, what's the word... not insult but, lack of trust I guess, from them to me.*

[INT002, 39 years old, Male]

### **5.2.3 Discomfort related to specific content of the MSE**

All of the trainees described how they felt awkward whilst conducting the MSE, providing a range of explanations or descriptions of what led to them feeling that way, including the wording of the questions utilised in the MSE, the structure of the MSE, personal insecurities, religion and the way in which the questions were received by the client.

One trainee described how the level of functioning of their client resulted in an uncomfortable introduction to the MSE.

*Umm... Like the introduction, in terms of introducing the MSE. That- that was okay. Because then it- I kind of normalised the process, just to tell them that, 'look this is*

*mandatory, I have to ask you these questions, umm, they may sound umm, a bit obvious but umm I just have to ask'. So that went well. Because what I say to them then- when I stress how, how obvious these questions are, its- its- it's almost as if I'm saying that nobody can't answer them. So when the client wasn't able to answer some of the questions, then it was awkward.*

[INT005, 25 years old, Female]

Whilst others found difficulty in asking the structured MSE questions regarding reality testing.

*I also feel weird getting to this point by the way, because there are certain days when I don't know the date so then I think to myself, can we really judge someone so harshly on the fact that they don't know the date? Sure the year I'd know and the month, but there are days when no- well, yeah it's been a stressful time and I sometimes don't keep up with the date and I think to myself, well if they don't know this do I really judge them that harshly on not knowing the date?*

[INT003, 22 years old, Female]

*What was difficult for me was the discomfort of actually asking some of the questions. Umm and some of these questions included hallucinations and delusions, and it was because I could see how uncomfortable the client was-*

[INT007, 25 years old, Female]

Many of the trainees described how some of the topics covered in the MSE such as the vegetative symptoms are difficult for them to cover without feeling discomfort.

*So I guess with practice and experience it has become much easier but still around those questions when it comes to um, the person's, I guess, sex drive, or when it comes to questions about their bowel functioning and stuff I, I'm still not too, I would say, comfortable asking about it and I think that's perhaps the cultural aspect coming into play where we don't really talk about certain things quite openly irrespective of how old you are.*

[INT003, 22 years old, Female]

Following on from this, many of the trainees struggled in particular to ask their clients about sexual functioning.

*Umm, ya I think that, I mean personally I, like when you asked about the sexual functioning, umm I don't think I've always been, I don't know maybe if it's to do with my culture or religion or something but talking about sex is not something you really do on your everyday basis and I think it's something I was a bit nervous to actually ask about.*

[INT001, 25 years old, Female]

### **5.3 CLIENT CHARACTERISTICS**

The trainees described varying experiences of the demographics of their clients, including the impact of age, gender and race. Issues of transference and countertransference were common experiences for many of the trainees, whilst others felt that the background of the client impacted on their ability to conduct the MSE.

*Age impacted it and gender, I guess, you know, if he- I would've um, age and gender definitely. I'm trying to think of an example of gender in this case but... perhaps my mannerisms I've- I've- as I've watched this thing I see myself sitting there being quite animated and I'm sitting there like this, almost it's striking me now as being, my posture and my mannerisms are more subdued when I'm talking to my female client, I'm kind of a bit more, like this (demonstrates), more still.*

[INT002, 39 years old, Male]

*Ya. The- the age part that you speak about umm... The reason why it didn't feel uncomfortable is because of her level of functioning. Otherwise umm from what I expected from a 31-year old definitely would have been, umm, uncomfortable because I mean this person is older than me.*

[INT005, 25 years old, Female]

Experiences held by the client, or the perceptions that the trainees held of the client resulted in varied explanations for how this impacted on the MSE. In most cases, the trainees felt that this played a role in relation to how they conducted the MSE.

*You see the reason there what I- why, the reason why I asked and was using a little bit of psychological sort of jargon in terms of simple sort of english is that she's an ex umm, masters student. So she like understands and even initially the way she was like umm, name-dropping and saying certain things she sort of has -back her- an understanding compared to a person who umm, never, who has never been trained at all.*

[INT004, 32 years old, Female]

Whilst one trainee described how the background of the client both aided and hindered them in conducting the MSE.

*And it also- excuse me- did not go well. The reason why I say it went well was eventually she did get to understand some of the questions I was asking but... it also didn't go well because I, I feel bad for the way I had normalised the questions and how she struggled to answer some of the questions.*

[INT005, 25 years old, Female]

### **5.3.1 Therapeutic Alliance Dynamics**

Issues of transference and counter-transference were common for the trainees. In some instances, this hindered the trainee's ability to conduct the MSE, whilst in other instances it helped them to feel more motivated to help the client.

*And I wonder if there's a masculine counter- transference with me, he's this kind of, driving in a Mercedes and he's this big, tall man and there's me the (pauses) being, counter- transferring a, the son, the role of son, and therefore, trying to express myself more animatedly.*

[INT002, 39 years old, Male]

*So there was a lot of, you know, transference/countertransference, at some point, I mean I remember some of my, one of my sessions I felt like I was just lecturing this, you know- Because I wanted her to get better but I'm not sure if it's for me or I was doing it to, you know...*

[INT006, 26 years old, Female]

Whereas some of the trainees felt more concerned about their client and in turn felt more motivated to help them.

*Really, really, really concerned, I cannot even begin to imagine, and the thing that worried me the most was that she ended up the session with wanting to pay for five sessions in advance and because we didn't have a machine with us we couldn't take her money, cause she said if I pay for five sessions in advance I have to come because I already spent the money and we don't have a machine here and she just paid for the one session and she didn't have enough money to pay for the rest of the sessions in advance.*

[INT003, 22 years old, Female]

Meanwhile, some of the trainees felt that the way their client perceived them or the MSE questions had a negative impact on their ability to conduct the MSE.

*What was difficult for me was the discomfort of actually asking some of the questions. Umm and some of these questions included hallucinations and delusions, and it was because I could see how uncomfortable the client was, so it was that matter of transference and countertransference.*

[INT007, 25 years old, Female]

### **5.3.2 Impact of Client's Emotional State on Administering the MSE**

One trainee described how the emotional state of the client greatly impacted on her ability to move forward with the questions in the MSE.



*I: Okay and then on the other side what did you find difficult whilst conducting the MSE with this client? The one that you mentioned was that her emotional state that was difficult...*

*Yes, ya. It made it difficult to actually contain and to proceed with the MSE as it felt like I would be insensitive towards what she was presenting with at the time.*

[INT004, 32 years old, Female]

## **5.4 CULTURE AND LANGUAGE**

A number of trainees described how both culture and language issues were prevalent whilst conducting the MSE. In all but one case, culture and language proved to be a barrier for the trainee in conducting the MSE.

Cultural and religious understandings of sensitive topics such as sex and mental health were described by some trainees to negatively impact the MSE.

*When it comes to um, the person's, I guess, sex drive, or when it comes to questions about their bowel functioning and stuff I, I'm still not too, I would say, comfortable asking about it and I think that's perhaps the cultural aspect coming into play where we don't really talk about certain things quite openly irrespective of how old you are.*

[INT003, 22 years old, Female]

*And I also, and I think one of the struggles was, you know, how do you phrase the question? Perhaps you want to talk about delusions of umm, grandeur -this person is a Christian and then if that person was to say, 'Yes I do hear voices from God', perhaps for some religion it's normal and you'd say, 'It's not, she's delusional'.*

[INT006, 26 years old, Female]

*So that cultural thing was there, age as well and for me I think the discomfort in not knowing if, since the client has a gender identity issue, will there be any... discomfort in terms of sexual attraction from the client because I'd read up about, you know, gender identity you know, dysphoria and how clients can get attracted to their- to their*

*therapists. So I was quite reluctant in, in actually asking some of the questions uhh, because of that. For example, libido in- in the MSE you know it was very difficult for me and I mean being a black person raised on- in a very... traditional home you don't ask people about their sex life. You don't ask- especially someone whom, you know, has a gender identity issue or difficulty.*

[INT007, 25 years old, Female]

In most where language was discussed by the trainees, it was described to negatively impact on their ability to conduct the MSE. Translation issues were common amongst the trainees.

*Umm, a rephrasing the questions from a language perspective because the MSE that I had, like the- the- the- the questions they were written in English and this client could not speak English so I had to rephrase them and ask them in- in a Zulu way you know. So some things they sounded more strange when they changed, you know, into another language.*

[INT005, 25 years old, Female]

*Umm thinking about this now, umm the fact that some of this was all- all of it was conducted in English there was sort of uhh, other meanings were lost there in terms of how we understand what anxiety is. So here I asked her about umm, 'Does she have excessive anxieties?', you know, so just checking her levels of anxieties but then there's no real term, appropriate term in isiZulu so sometimes anxiety is... is an... how can I put it, ummm... See it's even difficult for me to translate this to you but I could, you know, as I'm looking at this I could remember the feeling that was in the session there that, 'You know what, umm, there's some meanings lost here umm in in in the questions that I'm asking', so ya if- if I could improve something here would be, you know, sort of linking uhh the English and isiZulu language so that my client can better understand what I'm talking about.*

[INT008, 23 years old, Male]

One trainee described how being able to conduct the MSE in both English and isiZulu helped both the trainee and the client to understand the questions better.

*I think it did aid me in this situation because umm, even before asking about the MSE, asking about, you know, the other history... When I asked it in English the client would ask me to repeat and say, 'you know I didn't understand that'. So when I started asking in between like then in between English and isiZulu then I would get more responses there. So it's really a- a thing of the moment because the client can come in and say they speak purely isiZulu and you do the MSE in isiZulu and they don't understand. Umm but if you do it in English or use English and isiZulu interchangeably then they, you know they do understand.*

[INT007, 25 years old, Female]

## **5.5 SUMMARY**

The results section looked at four main themes. The first main theme, *Transition from Theory into Practice (Student to Clinician)*, included 5 sub-themes; *Experiences of Performance Anxiety – Self and Process*, *Developmental challenges – Personal and Professional*, *The Role of Prior Experience*, *Formal Training – Administering the MSE* and lastly *Coping Mechanisms used during administration of the MSE*. The second theme was that of *Process Issues in Administering the MSE*. Three sub-themes were discussed, notably; *The Importance of the MSE*, *Structured versus Unstructured administration of the MSE* and *Discomfort Related to Specific Content of the MSE*. The third theme looked at *Client Characteristics*, including two sub-themes of *Therapeutic Alliance Dynamics* and the *Impact of the Client's Emotional State on the Administration of the MSE*. The last theme discussed was that of *Culture and Language*.

## **CHAPTER SIX**

### ***DISCUSSION***

This study sought to understand the challenges experienced by trainee psychologists when conducting the Mental Status Examination with adult clients. Four major challenges faced by the trainee psychologists arose from the data: firstly, transitioning from theory into practice, secondly, process issues which arose whilst administering the MSE, thirdly, the client characteristics which impacted on the trainees' ability to conduct the MSE and lastly the influence of culture and language on MSE administration. These challenges are discussed in relation to findings from previous studies as well as the Developmental Model of Training (Skovholt & Ronnestad, 1992). Lastly, the implications of these findings are discussed.

### **6.1 TRANSITION TO PROFESSIONAL TRAINING**

#### ***6.1.1 Definition and Time Period***

This is the stage in which the participants found themselves, where they had entered into their first year of professional training at a master's level.

Unsurprisingly, the majority of participants described how they found the process of transitioning from purely theoretical knowledge as a student, to applying that knowledge as a trainee as incredibly difficult and overwhelming. This finding was in keeping with other studies in the area of personal and professional development of clinicians (Kanazawa & Iwakabe, 2015; Hill et al., 2007; Pascual-Leone, Wolfe & O'Connor, 2012). From a developmental perspective, the participants were in the stage of transition to professional training (Skovholt & Ronnestad, 1992), which accounts for many of the experiences that the participants described. This transition that the participants experienced describes the shift from the conventional mode, to the external rigid mode as illustrated by Skovholt & Ronnestad (1992). Despite this, it is important to consider that the time period covered by the stage model can vary greatly across stages and individuals, meaning that it may appear differently for different practitioners. This, however, highlights the strength of the phenomenological approach, in that the phenomena described by the participants and how they experienced them are of primary concern here. Throughout this transition, trainees are exposed to many experiences which can be noted as a 'critical incident', a

moment or experience that impacted either positively or negatively on the trainees' professional growth.

The external rigid mode, as Skovholt & Ronnestad (1992) describe, begins at the beginning of professional training, the space in which the participants found themselves during the study. At this stage, professional training becomes externally driven as the participants began to draw on external belief systems, which includes theories and knowledge learned throughout the process of training, as well as more experienced professional others such as supervisors and mentors. This could be seen in the way that some of the participants found it difficult to stay with the client and conduct the MSE at the same time. In addition to this, experiences of feeling overwhelmed at having to fit practice with theory, assimilating many new and old sources of information (through training), feeling both enthusiastic and insecure, as well as the urgency with which this needs to be done in the master's year provides a lens through which to view the experiences of the participants discussed below.

### ***6.1.2 Central Task***

The central task for the participants at this stage is simply the clinical evaluation of the client, in which the Mental Status Examination plays an important role. Coupled with this, participants are required at this stage to assimilate many different sources of information in order to apply it in practice. This has been alluded to above, where many of the participants struggled with this task and often found it overwhelming.

### ***6.1.3 Predominant Affect***

The predominant affect of the participants, for the most part, mirrored Skovholt & Ronnestad's (1992) stage model, where the participants would have been expected to experience both enthusiasm and insecurity. Many of the experiences described by the participants focused around their insecurity as a novice therapist, although the concept of 'growing' into the role was a prominent theme in the discourse of the participants. This concept of 'growing' into the role is an example of a positive critical incident, one that may lead to both personal and professional growth in the participants, as they choose to overcome their challenge and instead use it to further their own understandings and abilities.

Performance-based anxiety was a common factor amongst the participants. Performance-based anxiety related to the self included aspects such as disclosure of anxiety regarding competence and personal ability. Anxiety around competence and personal ability have been described by Heppner & Roehlke (1984) as major categories of critical incidents, and the ability of the participants to navigate these successfully has implications for their professional development. Participants also discussed how the reactions of the client during the session at times led them to feeling more anxious about their personal abilities. This experience is discussed in the literature, where trainees begin to feel self-conscious as a result of their performance-based anxiety and this in turn affects their ability to focus on their client (Skovholt & Ronnestad, 2003).

Performance-based anxiety which related to the process of administering the MSE was purely focused around the participants' lack of experience with the MSE. It is important to note that the MSE is quite a dynamic process that involves both structured questioning and unstructured processes such as observations and attention to expressive content, all of which can become overwhelming for the trainee psychologist to manage in a session. This lack of experience is important to consider as the focus of the study related to participant's initial exposure to the practical element of the course. It is of course expected that at that stage of the training, where participants are seeing their first adult clients, they will feel inexperienced and feel underprepared when it comes to administering the MSE. The importance of this, however, may indicate the depth of the training which the participants received prior to conducting the MSE for the first time. Educating students around fear and performance-based anxiety, coupled with creating a nurturing and relaxed learning environment has been shown reduce classroom anxieties and improve student engagement and performance (Bledsoe & Baskin, 2014). This is an example of lessening the potential negative impact of the critical incident surrounding training, where the quality of the training has an influence on the participants' professional development.

Unsurprisingly, personal and professional challenges permeated the experiences of the participants. Some of the participants described how their own personal strengths and weaknesses were difficult to deal with or hindered them at times from learning. Despite this, all of the participants noted that this process of 'growing' was beneficial to them throughout the course of the year and aided in their personal and professional development (note the positive

influence of the participants' realisation of the critical incident). One participant described how their own struggle and experience with mental illness proved to be a barrier in conducting therapy with a client. It is difficult to fully understand the impact that the participant's personal lives would have had on their ability to conduct the MSE, but as Skovholt & Ronnestad (1992, p.512) note, "both difficult and normative life experiences continually affect the professional". Many of the participants described how their own personal experiences in life either hindered or aided them. In most cases, the realisation of the impact that the personal experience had on the development of the participant and their ability to conduct the MSE provided a positive learning experience, which would also be considered as a critical incident in the growth of the participants.

As was expected, certain questions in the MSE would be more uncomfortable for the participants to ask than others. A range of explanations for this discomfort was given by the participants such as the wording of the MSE questions, the participant's own personal insecurities and anxieties around questions such as sexual functioning or religion, and in one case the level of functioning of the client led the participant to feel discomfort as they were not sure if the participant fully understood the MSE questions.

#### ***6.1.4 Predominant Sources of Influence***

Skovholt & Ronnestad (1992) describe how many new and old interacting databases of knowledge may overwhelm therapists at this stage, which was found to be the case for each of the participants.

Training was a topic covered frequently by all of the participants. In terms of actual skills development (training), a number of factors contributed towards misperceptions regarding how to conduct the MSE. These included: administration (content and enquiry) and the format and structure of the MSE. No standardized MSE document was made available to the participants, as is suggested by Daniel & Gurczynski (2010). Instead, participants were expected to formulate their own MSE questions based on theoretical texts with minimal guidance. Coupled with this, many participants felt frustrated that role-plays were the only form of practical training surrounding the MSE. Although the hospital placements were useful for participants in terms of being able to observe experienced professionals administer the MSE, these placements only began after the participants had already started consulting clients at the UKZN Psychology

Clinic. As such, training was pointed out by many of the participants to be a critical incident in their understanding of the MSE, as well as in their ability to successfully conduct the MSE with an adult client.

#### ***6.1.5 Role and Working Style***

The role and working style described by Skovholt & Ronnestad (1992) is that of uncertainty and constant shifting due to the struggle of incorporating both practice and theory. The experiences of the participants varied in this regard, as some were more capable of finding a comfortable working style than others. Factors such as prior experience and age may have impacted on this, but were beyond the scope of this study.

When it came to administering the MSE, the participants reported both positive and negative experiences. As was expected, the participants recognised the importance of conducting the MSE and the value that it holds in relation to diagnosis and formulation of clients. Surprisingly, the participants were divided on whether or not the structured nature of the MSE was beneficial to them or not. Some participants felt free to ask the MSE questions throughout the clinical interview, eliciting valuable information that otherwise may not have come up naturally. Other participants felt incredibly limited by the structured nature of the MSE, describing how the MSE did not allow them to probe further with certain topics as the participants felt that they needed to cover the rest of the MSE questions. One participant, however, felt a sense of comfort in the structured MSE questions and chose to write them up beforehand to follow as a type of interview guide.

Some participants found the flexibility beneficial and they used to MSE questions to direct the session, or they found that the MSE questions fit in well with the overall process of the clinical interview. This was to be expected as the MSE is best utilised when it takes on a “conversational quality”, as Daniel & Gurczynski (2010, p. 62) state. In other cases, some participants felt that the structure of the MSE restricted their ability to obtain crucial information from their clients.

Unsurprisingly, all of the participants discussed the difficulty they had with the wording of the questions used in the MSE. Explanations for this difficulty ranged from feeling uncomfortable when asking the questions, to simply not knowing how to phrase or word the questions.



### ***6.1.6 Conceptual Ideas***

Developmentally, the participants at this stage would have experienced the urgency in learning conceptual ideas and techniques that is described by Skovholt & Ronnestad (1992), which would then classify the participants as stage appropriate.

This was the case for the participants, where they were constantly learning new ideas and techniques. In some cases, the participants felt that they did not have enough guidance when it came to wording the actual MSE questions, which often led to them feeling either uncomfortable or worried about how the client would perceive them in terms of professionalism and competency. Interestingly, one participant described how the lack of a translation of the MSE from English into isiZulu greatly inhibited their ability to conduct the MSE with isiZulu clients, and often the meaning of the MSE questions would be lost in translation. This critical incident is important to consider in light of the multi-cultural context in which the participants found themselves, where the ability to utilise the MSE across language and culture barriers would be beneficial not only for their own professional development but also for psychological assessment in South Africa as a whole. With regard to the urgency described by Skovholt & Ronnestad (1992), questions can be raised surrounding the urgency, where more time and experience with conducting the MSE could be utilised in order to help the trainees adjust to this challenging experience.

As described above, all of the participants recognised the value and importance of the MSE as a screening evaluation. Despite this, many participants found difficulty in effectively incorporating the MSE in the session without feeling as if they were damaging the therapeutic alliance. One participant even suggested that the structured portion of the MSE should perhaps be situated in the very beginning of the clinical interview. Therapist orientation (Client-Centred, Psychodynamic, etc) may have a role to play in relation to comfort around conducting initial interviews, although more research is needed in this area and was beyond the scope of the current study. Tension would arise when a clinician has to acquire information from a semi-structured examination such as the MSE, where they would find difficulty in positioning it as part of the initial interview.

The conceptual system (the conceptual frameworks of understanding the participant engages with or utilises to make sense of clients) of the participant, as well as their working style may

account for the difficulty or ease with which the participants were able to utilise the MSE in the session. This is discussed by Skovholt & Ronnestad (1992) as the need for the conceptual system and working style to be congruent with the individual's personality and cognitive schema. This is why some participants may have felt more comfortable with a flexible style, where they were able to meet the 'authenticity-to-self' requirement, whilst others found it difficult and restricting, or incongruent to their personal authentic style.

#### ***6.1.7 Learning Process***

The most prominent process of learning at this stage is through cognitive processing and introspection (Skovholt & Ronnestad, 1992). Other forms of learning may take place as well, although, as is expected during the first year of professional training, the participants' would have primarily engaged in cognitive processing and introspection throughout their training.

As mentioned previously, the role of prior experience greatly impacted on the participant's ability to conduct the MSE. All of the participants noted how their ability to administer the MSE had improved with each administration. Again, this relates to the complicated nature of the MSE as well as competency being developed over time. Although not strictly a 'critical incident', but rather a set of incidents across the training year, participants were able to point back to some critical points in their understanding of the MSE, such as how some participants described how watching others administer the MSE at hospital placements greatly aided them as they were able to observe experienced others. This use of modelling as a learning method is described by Skovholt & Ronnestad (1992) as powerful in the early years of professional training, and in all cases was described by the participants to enhance their understanding of the MSE. In some cases, the participants described how supervision helped them to fill the gaps in their knowledge and experience as they were able to rely on the experience of their supervisor. Supervision was found to be a notable critical incident for some of the participants, which is in line with Furr & Carroll's (2003) findings. Contrary to this, one participant stated that supervision was almost not enough, which intensified their sense of incompetence. Professional supervision served both as a positive resource and as an effective training strategy that augmented trainees' theoretical and practical exposure in their respective fields. This process, which is a component of the Psychology Practice module, served as a platform/resource in relation to the following: developing technical skills and the integration of therapy; ethics and code of conduct in

psychology practice and psychological assessments and theory. This is important to note as an increased reliance on the ideas and knowledge of supervisors may be considered to be a precursor to the third stage of the model, 'Imitation of Experts'. Although the participants did not enter into this stage of the model during the course of the study, the transition to the next stage is evident in the way the participants experienced supervision interactions.

An interesting finding was how the emotional state of the client impacted on one participant's ability to conduct the structured MSE questions. In this case, the participant felt that they needed to attend to the client's emotional distress instead of complete the MSE. Two of the participants noted how the structured MSE questions led them to feel as if they were being condescending to their clients. This, however, could be a question of experience and competency with the MSE as a screening evaluation tool. In both cases the participants described that it was the act of asking questions which they already knew the answers to which led them to feel condescending. What becomes apparent, then, is the importance of the perception that the participants held of the MSE as a screening tool. Some participants focused solely on the structured element, whereas others chose to focus on the observation and reflection elements of the MSE, which led them to experience difficulties with the aspects of the MSE which they were not entirely familiar or experienced with. It would seem then, that the critical incident regarding the participants' perception of the MSE resulted in different outcomes for the way in which the MSE was conducted. Changing or developing the participants perceptions of the MSE through a more thorough training could be a way of increasing their ability to navigate between structured questioning, observation and reflection of expression and form of information elicited during the clinical interview.

Client characteristics were found by all of the participants to be a challenge when it came to administering the MSE. Differences in age, gender and race were common factors which led to the challenges faced by the participants. These differences were noted to be critical incidents, as they greatly impacted how the participants conducted the MSE. Similarities between the participants and their clients did not always lead to an improvement in their ability to conduct the MSE. Interestingly, two participants reported how the background of the client impacted their ability to conduct the MSE. In one case, the client was a psychology master's graduate, and so the participant felt uncomfortable to continue with the MSE questions as they felt intimidated by

the student's knowledge. In another case, the low level of functioning of the client actually aided the participant to conduct the MSE, as they felt more relaxed and comfortable knowing that they would not be judged on their ability. It seems as if in most cases, the perception that the participants held of the way their clients perceived them was a barrier to effectively conducting the MSE. This is in line with previous findings in the literature, where trainee psychologists have been found to experience incredible anxiety around disappointing their supervisor and client (Skovholt, 2012). Participants were frequently concerned with how they themselves would be perceived by their clients in terms of their own professionalism and competency. Again, this is consistent with previous findings, where trainee psychologists experienced anxieties around the fear of failure or incompetence (Eagle, Haynes & Long, 2007; Thériault, Gazzola, & Richardson, 2009). This is important to note as Skovholt & Ronnestad (1992) describe the role that clients play as teachers during professional training, where the participants would have received feedback on themselves as a person and as a professional. A crisis at this stage which was not as evident in the results was that of a lack of client improvement, and the implications it has on the development of the participants. This is perhaps a result of the study being conducted at a single point in time and not as a longitudinal study, where the impact that the participants had on their clients would have been able to be explored.

#### ***6.1.8 Measures of Effectiveness and Satisfaction***

Visible client improvement and satisfaction, as well as supervisor reaction is described as the primary measure of effectiveness and satisfaction at this stage by Skovholt & Ronnestad (1992). As such, the coping strategies employed by the participants' offers an interesting perspective on their own perceptions of effectiveness and satisfaction.

As was expected, all 8 of the participants described a range of coping mechanisms when it came to administering the MSE. Nervous laughter, discomfort such as shuffling papers, fidgeting and the use of external instruments (such as clipboards) to mask their anxiety were utilised as coping mechanisms by the participants. Respondents provided a number of reasons for this including their discomfort with the MSE questions, the anxiety of conducting their first session with a client and their lack of competence in conducting the MSE. It appears then, that the MSE is far more complicated and difficult for the participants to administer, especially in the context of their first practical exposure. This, however, is in keeping with Skovholt & Ronnestad's (1992,

p. 512) model of professional development, where “a crucial factor in the decline of pervasive anxiety is the increase of expertise, which results from long periods of experience and training”.

As was expected, the therapeutic alliance was frequently described by the participants to impact on their ability to conduct the MSE. The therapeutic alliance was considered to be a critical incident as it had implications for how the participants conducted the MSE, and it also impacted on the participants’ measure of effectiveness and satisfaction. This difficulty in developing the therapeutic alliance has been found in previous studies, where a number of challenges such as the ambiguity of the therapeutic process (Eagle, et al., 2007), confusion around the ability to navigate personal and professional roles (Hill et al., 2007) and the fear of rejection (Goodyear, Wertheimer, Cypers, & Rosemond, 2003) are all prominent. Many of these challenges were consistent with the participants of this study’s experiences of conducting the MSE. Transference and counter-transference issues were described by some participants to limit their ability to conduct the MSE. Demographic variables such as age and gender were described by the participants to contribute to transference difficulties in the session. One participant described how, when completing the structured element of the MSE, they felt uncomfortable when the client struggled with the serial 7’s (a mathematical task which involves counting backwards from 100 by subtracting a series of 7’s) task as the trainee expected the client to have no difficulty due to their age. Similarly, some trainee’s felt uncomfortable when talking to a client who was of the opposite gender to them. This was reflected in the way that one of the participants omitted questions on the client’s sexual history in the MSE. Another of the trainee’s attributed their discomfort with the gender of client as a reflection of the client’s presenting problem, a gender-identity issue. In contrast to this, other participants utilised the counter-transference as a motivator for them to assist their clients. Issues with transference and counter-transference and the ways in which the participants responded to them illustrate the ability of the critical incident to further or hinder the professional growth of the participants. In terms of the developmental model outlined by Skovholt & Ronnestad (1992), clients play another crucial role in the counsellor development which is as a measure of effectiveness and satisfaction in the trainee. This occurs due to the close interpersonal relationship held by the therapist and client, where the therapist continually receives feedback on themselves as a person. This feedback may occur directly when providing specific feedback on processes in the session, or feedback may be provided through client improvement (Skovholt & Ronnestad, 1992). This is important in the

early years of counsellor development, particularly during the transition to professional training, the stage in which the participants found themselves.

#### ***6.1.9 Contextual Factors***

Contextual factors which may affect counsellor development were not explicitly taken into account in the stage model developed by Skovholt & Ronnestad (1992), and no theme focusing specifically on contextual factors was included. Although contextual factors such as the social and cultural environment are alluded to, they are not described in depth as a part of the stage model. Despite this, culture and language are two contextual factors which were found in this study to have an impact on the participants' experiences of conducting the MSE.

Language was frequently described by participants to inhibit their ability to conduct the MSE, with only one participant stating that this did not affect their session with a client. The most prominent language issue was the lack of an isiZulu translation of the MSE questions. This lack of translation was a major critical incident for the participants who encountered this difficulty, and it resulted in them feeling uncomfortable about how they conducted the MSE, with most feeling like the client did not fully understand them or give adequate responses. Considering the MSE has been used in the South African context for decades, it is surprising that such a translation has not yet been developed. There have been successful validations of other psychological assessments in South Africa such as the SCL-90-R, a 90-item self-report inventory which was translated into isiZulu and found to be a useful instrument for the evaluation of psychological distress and screening for mental illness in Zulu-speakers (Shanahan, Anderson & Mkhize, 2001). This instrument, however, is out-dated and further revisions would need to be validated in order for it to be valid in the current South African context. Despite this, Shanahan, Anderson & Mkhize (2001) have shown that translation and validation of psychological instruments is possible and crucial to the South African context, where there are many different languages and cultures, all of which experience and describe mental illness in different ways. Similar difficulties in translation were described by Bunting & Wessels (1991), where multiple terms were found to be used in the Zulu language for concepts such as 'depression' or 'anxiety'. This calls into question the role of psychology in South Africa, considering the part that psychology as a profession played in the socio-political climate during the Apartheid years (Pillay & Kramers-Olen, 2012). Again, the suggestion by Ahmed & Pillay (2004) for psychology

as a profession in South Africa needing to realign its goals is still pertinent 15 years later. One participant, however, found that being able to use English and isiZulu interchangeably as a means of conducting the MSE was more beneficial than just asking the MSE questions in one language. This suggests that once an isiZulu translation of the MSE is formalized it can be used to great effect in the South African context.

As noted by Skovholt & Ronnestand (1992), the social and cultural environment in which the participants find themselves greatly impacts on both the micro level (within the therapy session) and the macro level (the larger society and culture). These sources of influence are common to all of the participants, although the authors note that the timing, intensity and the pace with which this unfolds throughout the development of the participant is unique to each of them. This was seen in the way that culture affected some of the participants negatively, whereas others found that their own cultural understandings enhanced their ability to connect with their client.

Culture also played a part in the participant's ability to conduct the MSE. Although not as frequent as issues of language, cultural dynamics were cited by participants to negatively impact on their ability to conduct the MSE. This has also been the case throughout the literature, where anxieties about difference (be it culture, race, religion or age) have been described to impact negatively on the therapeutic alliance (Cartwright & Gardener, 2015). Explanations for this ranged from topics such as sexual functioning to religious beliefs. Many participants described how, in their culture, the topic of sex was not socially acceptable to speak about, especially when it involved a woman asking a man about his sexual functioning. With regards to religion, one participant described their difficulty at discerning whether or not the client's religious beliefs accounted for what the client was experiencing. The idea of conceptualizations about health and wellness discussed in the literature (Edwards et al., 2011; Mkhize, et al., 2016) was not prominent in the results of this study, as participants chose to focus more on practical aspects whilst conducting the MSE. It is possible that the lack of focus on African Indigenous Knowledge Systems (AIKS) in the curriculum of masters' programmes in South Africa (Chitindingu & Mkhize, 2016) led any cultural issues to be viewed by the trainees through the lens of the Western Biopsychosocial approach, and thus it may have appeared that such issues were not in conscious awareness during sessions with clients. This does not mean that those

conceptualizations were not present during the clinical interview, and is perhaps an area for further research.

One possible explanation for the lack of attention to cultural explanatory models of illness can be attributed to the dominance of the Biopsychosocial model (an interdisciplinary model that looks at the interconnection between biology, psychology, & socio-environmental factors) (Engel, 1977). The model specifically examines how these aspects play a role in conceptualizing health & disease models and human development (Burkett, 1991). Within the developmental model of counselor development (Skovholt & Ronnestand, 1992), much of the tension around cultural dynamics experienced by the participants can be understood as the very transition which the participants were experiencing. Prior to professional training, the participants would have solely relied on personal life experiences and common sense ideas about the way the world and people work, which is directly influenced by their own culture. This transition then can account for some of the difficulty and tension that the participants experienced around culture, where they struggled to integrate the different ways of understanding their clients. The process of ‘professional individuation’, as described by Skovholt & Ronnestand (1992), occurs throughout the developmental trajectory of a counselor, where they attempt to integrate both their personal and professional selves. Part of this process includes the navigation of culture and language dynamics, which was apparent in the experiences of the participants.

#### ***6.1.10 Summary***

This section attempted to place the themes from the results within the context of the stage model developed by Skovholt & Ronnestad (1992). In addition to this, critical incidents which influenced the personal and professional growth of the participants were noted throughout the discussion. Only the second stage of the model was considered, as that was the stage the participants found themselves in during the course of the study. The results were discussed in relation to the eight categories or themes identified by Skovholt & Ronnestad (1992).

The first category focused on the definition and time period of the participants’ developmental trajectory, which included the participant’s first year of professional training. The second category was concerned with the central task of the participants, which was to clinically evaluate clients and involved participant’s navigation of knowledge assimilation. Thirdly, the predominant affect of the participants was discussed, which focused on performance-based



anxiety and personal challenges which the participants experienced, all of which contributed to their professional development and ability to conduct the MSE. The fourth category, predominant sources of influence, focused around the training of the participants and the misperceptions of the participants around the use of the MSE. The fifth category focused around the role and working style of the participants, which was reflected in their level of comfort with using both the structured and unstructured elements of the MSE. The sixth category, conceptual ideas, discussed the difficulty which the participants experienced when it came to incorporating new conceptual ideas in clinical practice. The seventh category focused on the learning process of the participants, which ranged from observation and modelling of experienced practitioners, to supervision and client feedback. The eighth and last category, measures of effectiveness and satisfaction, included the influence of supervisory reactions and client improvement as a marker for effectiveness; specifically focusing on the role of coping mechanisms, the influence of the therapeutic alliance and transference/counter-transference issues. An additional category, contextual factors, was also included in this section where the role of cultural and language issues were discussed, although it did not form a part of Skovholt & Ronnestad's (1992) Stage Model of Counsellor Development.

## CHAPTER SEVEN

### *CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS*

This final chapter aims to provide a short summary, conclusion, and the limitations of this study, as well as provide some recommendations for future research. Lastly, a personal reflection on the research process is included.

#### **7.1 STUDY SUMMARY AND CONCLUSIONS**

The aim of this research was to explore the challenges faced by trainee psychologists' when conducting the Mental Status Examination with their first adult client. Eight trainee psychologists currently enrolled in the Clinical/Counseling Psychology Masters' programme at the University of KwaZulu-Natal participated in the study (two male, six female) and the results of this study provided insights into the challenges which they faced. Skovholt & Ronnestad's (1992) Stage Model of Counselor Development provided a framework in which to make sense of the data, placing the trainees within the stage of *Transition to Professional Training*. The results of this study highlighted some of the limitations of this model, most notably the impact of culture and language on the development of the trainee, which was not conceptualized as an identifiable theme within Skovholt & Ronnestad's original model. Although the authors alluded to the impact of the macro and meso-system as being unique and specific to the individual, numerous cultural and language factors play an important role in the development of the trainees within the multicultural context of South Africa.

The results of this study illustrated that the experience of training to become a psychologist is a universally difficult and oftentimes overwhelming experience that with time and support, allows a trainee to grow into a professional. What was found was that training in mental health assessments was predominantly influenced by Western conceptualizations of mental illness. With progressive development in the field of Indigenous Knowledge Systems (Mkhize, Ndimande-Hlongwa, Nyowe, Mtyende & Akintola, 2016; Chitindingu & Mkhize, 2016) it is envisaged that such knowledge would inform the practice of psychology in South Africa (cultural attributions and meanings of mental illness) towards more comprehensive assessments of mental health states. Simply adapting and validating psychometric instruments to suit the South African context (Shanahan, Anderson & Mkhize, 2001), although valuable and necessary

in the short term, is not enough if true transformation in the field of psychology in South Africa is to occur throughout the years to come. More focus needs to be placed on the development of South African psychometric assessments, where the data is collected in the population groups in which many South African psychologists serve. As noted previously, there has been much progressive development in the field of Indigenous Knowledge Systems (Mkhize, et al, 2016; Chitindingu & Mkhize, 2016) and yet the reliance on Western theories and ideas is still prominent, even in the teaching of trainee psychologists.

With regards to the MSE specifically, as that was the focus of the current study, changes in the teaching of the MSE emerged as one significant change that is possible for training institutions to implement. Even the simple realisation that the teaching of the MSE is a major critical incident in the professional development of trainees is a step in the right direction. Additionally, translating the MSE into different languages such as isiZulu is a difficult but necessary step to take if the MSE is to be a valid psychometric assessment across South Africa. This is made more crucial considering that majority of South Africans do not consider English as their home language, and is in most cases a second additional language at best. Utilising task teams made up of experienced psychologists who are fluent in both languages (taking into account cultural differences as well) would be one way to begin the translation process. Of course, there are many more languages spoken across South Africa, with there being 11 official languages, and so translating the MSE into isiZulu would be the first step towards improved validity in the MSE as a psychometric assessment.

Although it is very difficult to justify the generalisability of a study which is qualitative in nature, the experiences of the trainees offers a valuable insight into the various challenges which may inhibit their ability to understand and utilise important skills which are necessary in their future roles as practicing psychologists. Of course, as was discussed above, the challenges described in this study were specific to the Psychology Master's Programme at the University of KwaZulu-Natal, but the experiences of the trainees were similar to some of the experiences described by Skovholt (2012) and Morrison (2014).

## **7.2 LIMITATIONS**

The limitations of the current study refer to how the selected research design or methodology may have influenced the outcome of the findings.

The following study limitations are acknowledged:

### ***7.2.1 Diversity of the sample***

This study is limited in terms of the diversity of the sample. Six of the eight participants were female. Due to the purposive sampling and the response rate of the participants, most of the participants were female, despite efforts to incorporate a balance between male and female participants. However, gender diversity was not a necessary criterion for selection of participants and did hinder the results of the study.

The sample utilised in this study was limited as it was restricted to a single university, the University of KwaZulu-Natal. Further studies incorporating trainees from multiple universities across South Africa may yield more comparable results. Similarly, at the time of the study, the participants were all current course attendees at the University of KwaZulu-Natal, and so the results of this study may not be generalizable to trainees who previously attended the UKZN Psychology Master's Programme.

### ***7.2.2 Data-collection method***

The data were collected using face-to-face semi-structured interviews. Face-to-face interviews have a number of advantages in data collection including higher response rates, interview flexibility and the ability for follow up questions to improve clarity for both the interviewer and interviewee (Szolnoki and Hoffmann, 2013). One of the disadvantages, however, is the introduction of bias during the interview process. As the interviews were semi-structured in nature, the use of probing questions were necessary in order to gain further understandings of the participants' experiences which allowed for the introduction of bias in terms of which probes were used to gather additional information. In addition to this, interviews are often time-consuming and many of the participants found it difficult to find time for the interview due to their busy seminar schedule and client appointments. As a result, some of the interviews were shorter than originally expected. Despite this limitation, the research achieved the aim of exploring the challenges faced by the trainees when conducting the Mental Status Examination.

### ***7.2.3 Generalizability of findings***

As is the nature of qualitative studies, the results described above may not be generalizable to a wider population and so further research will need to be done within other Psychology Master's

programmes in order to gain a greater understanding and perspective of the challenges faced by trainee psychologists in other institutions.

Additionally, as the sample was predominantly female, the results of the study may not be generalizable to male trainee psychologists.

#### ***7.2.4 Theory-driven versus Data-driven research***

This study attempted to achieve a balance between the theory-driven and data-driven approach. The core assumption of a theory-driven approach is that data is given meaning when it is interpreted in relation to an existing theory (Wallander, 1992); this study utilized Skovholt & Ronnestad's (1992) Stage Model of Counselor Development to place the collected data into context. In contrast to this, a data-driven approach to research emphasizes the gathering of larger amounts of data which is then used to generate a theory (Wallander, 1992). A limitation then of a theory-driven approach is that the data is guided, and influenced, by the theory. Subsequently, utilizing this specific model may have hindered the exploration of additional themes and experiences in counselor development.

#### ***7.2.5 The researcher himself***

As the researcher is a male, English-speaking, trainee psychologist, it is possible that the data was interpreted against his pre-existing understandings and interpretations of the MSE, as well as his experience of the UKZN Clinical Psychology Masters' Programme. Thus, the presence of bias is possible within the study. However, constant effort was made to be self-reflective during the process of the study, and guidance was sought from the research supervisor in this regard.

### **7.3 RECOMMENDATIONS**

Based on the results of this study, the following recommendations are provided for conducting further research:

- *To explore the influence of language and culture and how this gets factored into the process of mental health assessments.*

The focus of this study was on that of the Mental Status Examination. In order to improve the training of psychologists at training institutions across South Africa, studies around the

impact of language and culture on the process of mental health assessments would be valuable to explore.

- *To explore gender differences in relation to mental state assessment use amongst trainee psychologists.*

As noted above, the participants of this study were mainly female, and so the results are not an accurate representation of male's experiences of conducting the MSE during training.

- *To explore trainee psychologists' understanding of African Indigenous Knowledge Systems and their impact on the expression of mental illness*

Further specific research is recommended in this area. Although issues of language and culture were prominent in the results of this study, the exploration of the impact that African Indigenous Knowledge Systems had on the expression of mental illness was not evident, and so further research in this area may lead to improved training programmes across South Africa.

#### **7.4 SELF-REFLECTION**

This study topic was chosen by the researcher himself due to his own experiences of the Clinical Psychology Masters' programme and his experience of the use of the Mental Status Examination within the Masters' training year. Through talking to other trainees in the masters' programme and hearing about the challenges which they faced when it came to conducting the MSE, the researcher planned to explore why so many of the trainees found the MSE so difficult to use in practice. In addition to this, the masters' year was the first clinical/counseling setting in which the trainees would need to utilize highly specialized information in order to clinically assess clients, and so this led to the question of how to lessen the challenges faced by the trainees. The researcher utilized an ethnographic approach in the course of this study, fitting the role of a participant-observer. This afforded the researcher a unique perspective on the experience of being a trainee psychologist and having to learn and use a clinical assessment such as the mental status examination. As such, the researcher's experiences of being a trainee positioned him to explore the phenomenon which formed the basis of the inquiry. This also led to increased insight when designing the research instrument. As a result of this stance, the researcher was aware of

the inherent bias that may be present throughout the research, and constant reflection on the research process was utilized in order to maintain objectivity. Similarly, the researcher made the effort to report only on the phenomena that was observed or described by the participants, and the emotions and feelings of the researcher were excluded wherever possible from the research process. Of course, the very nature of a participant-observer and the researcher's unique position as a trainee psychologist makes objectivity difficult, which is why the study attempted to maintain a balance between a theory-driven and data-driven approach.

The results of this study provided the researcher with useful insights into the challenges that the trainees face when using the MSE and he hopes that the information gathered may be useful in helping training institutions across South Africa to improve their Clinical/Counseling Psychology training programmes.

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## APPENDICES

### APPENDIX 1 – SEMI-STRUCTURED INTERVIEW SCHEDULE

#### a) Interview Questions

##### ➤ Screening Question

Have you conducted the Mental Status Examination with an adult client?

YES ☐

NO ☐

*(Please note that the following questions are the structured questions for the interview and that unstructured questions and probes may be used where applicable in each individual interview. Examples of probing questions have been supplied herewith)*

1. Could you please tell me a little about yourself?

**\*Probe:** -Current age

-Marital/relations

-Highest level of education

-Culture/Race

2. What has your experience as a developing clinician been like so far?

**\*Probe:** -Talk me through your first interview with an adult client?

3. What has your experience of conducting the Mental Status exam been like?

- \*Probe:** *-Can you speak about your experience in the video clip you chose to bring?*  
*-What did you find went well whilst conducting the MSE with that client?*  
*-What did you find difficult whilst conducting the MSE with that client?*

4. What would you say was the reason for your particular experience?

- \*Probe:** *-Personal Characteristics*  
*-Clarity of what was expected*

5. What other influences, if any, do you think impacted on your ability to conduct the Mental Status Examination

- \*Probe:** *-Cultural influences*  
*-Age differences*

### **General Questioning**

1. Did you find this interview and its questions understandable?
  - a) If you responded no, please specify where you encountered a problem.
2. Is there anything else you wish to add or clarify?

## *APPENDIX 2 – CONSENT FORMS & ETHICAL CLEARANCE*



School of Applied Human  
Sciences  
Discipline Psychology  
College of Humanities  
University of KwaZulu-Natal  
Howard College Campus  
Durban, South Africa

**Date:** \_\_\_\_\_

### **a) Information sheet and consent to participate in research**

Dear Participant

I am a Masters student in Psychology at the University of KwaZulu-Natal (Howard Campus). I am required to do a research dissertation as part of my training. My research investigates the challenges faced by trainee psychologists when attempting to conduct a Mental Status Examination with adult clients.

You are being invited to consider participating in a study that involves answering questions about your experiences of conducting the Mental Status Examination. Your participation is **voluntary** and you are entitled to withdraw from the study at any time without any consequences or prejudice. The study is expected to enrol 8 people. It will involve myself asking you a set of semi-structured questions and possibly others if necessary, as well as asking you to pick a short video showcasing a challenging moment whilst conducting the Mental Status Examination. The duration of the interview should be approximately 20-30 minutes.

The study involves myself asking you the questions, with some of your answers being recorded on a prepared questionnaire sheet, however, the interview will be recorded using an electronic device for the purpose of documenting your true thoughts and ideas and to ensure that none of the results of this study are fabricated. The study will not provide any direct benefits to you, the



participant, but it will help in gaining more knowledge on the challenges faced by trainee psychologists. There are no risks involved in the participation in this study.

This interview will not record your name or address – just a study number. Confidentiality of your personal/clinical information will be protected at all times.

In the event of any problems or concerns/ questions, you may contact the researcher, Marc Greener; or the supervisor of the study, Mr Sachet Valjee.

If you have any queries regarding the rights of research respondents, please contact the HSSREC Research Office: University of KwaZulu-Natal, Westville Campus.

**Contact Details:**

**1. Researcher:**

Marc Greener

Tel: 079 074 1651

[mdgreener@gmail.com](mailto:mdgreener@gmail.com)

**2. Project Supervisor:**

Mr. S. Valjee

Tel: 031 260 7613

**3. HSSREC Research Office:**

**UKZN, Westville Campus**

Tel: 031 260 8350

**b) Declaration of Informed Consent:**

I, \_\_\_\_\_ have been informed about the study entitled “A qualitative understanding of the challenges faced by trainee psychologists when conducting a formal Mental Status Examination during the Clinical Interview” by.....

- I understand the purpose and procedures of the study.
- I have been given an opportunity to ask questions about the study and have had answers to my satisfaction.
- I declare that my participation in this study is entirely voluntary and that I may withdraw at any time.
- I also consent to the interview being electronically recorded (audio only).
- If I have any further questions/ concerns or queries related to the study I understand that I may contact the researcher at.....
- If I have any questions or concerns about my right as a study participant, or if I am concerned about an aspect of the study then I may contact:  
Mr S. Valjee (Project Supervisor), University of KwaZulu-Natal (Howard Campus) at  
031 260 7613

I hereby consent / do not consent to have this interview recorded:

**Signature of participant:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Signature of witness:** \_\_\_\_\_

**Date:** \_\_\_\_\_

(where applicable)

**Researchers' Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

(.....)

### c) Gatekeeper Permission Form

**Date:** 19/06 2017

To whom it may concern

I am a Masters student in Psychology at the University of KwaZulu-Natal (Howard Campus). I am required to do a research project as a part of my training. My research topic is “A qualitative understanding of the challenges faced by trainee psychologists when conducting a formal Mental Status Examination during the Clinical Interview”.

This is a qualitative, explorative phenomenological study and will involve the use of semi-structured questions in the form of a personal interview, as well as the use of a short-video clip which forms a part of Interpersonal Process Recall (IPR) to obtain the information needed from eligible and consenting clients, which will eventually form the basis of my study.

All information collected from the participants will be done with duly informed consent from the participating clients and the clients can refuse participation and/ or withdraw participation at any point of the study.

I am therefore, requesting your permission to use the clients which you find to be suitable as participants in my research.

Please feel free to contact me if you have any queries. Alternatively, you may wish to contact my supervisor Mr. Sachet Valjee, if you would like a reference or any other information.

Yours sincerely,

**Name:**

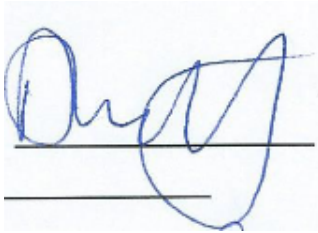
**Contact details:**

**Email:**

If you are willing to participate, would you please sign the form below that acknowledges that you have read the explanatory statement, understand the nature of the study being conducted and you give permission for the research to be conducted at the site.

I [Name: Prof Cantongkit] as [Role/ Title:] of [Site: Masters Coordinator] having been fully informed as to the nature of the research to be conducted give my permission for the study to be conducted. I reserve the right to withdraw this permission at any time.

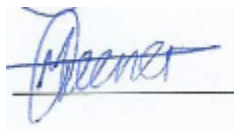
**Signature:**

A handwritten signature in blue ink, appearing to be 'Cantongkit', written over a horizontal line.

**Date:** 19.6.17

**Researchers' Signature:**

**Date: 19/06/17**

A handwritten signature in blue ink, appearing to be 'Greener', written over a horizontal line.

(Marc Greener)

## d) Ethical Clearance Form



18 July 2017

Mr Marc David Greener (211521836)  
School of Applied Human Sciences – Psychology  
Howard College Campus

Dear Mr Greener,

Protocol reference number: HSS/0683/017M

Project title: A qualitative understanding of the challenges faced by trainee psychologists when conducting a formal Mental Status Examination during the Clinical Interview

### Approval Notification – Expedited Application

In response to your application received on 02 June 2017, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

**PLEASE NOTE:** Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

Dr Shenuka Singh (Chair)

/ms

Cc Supervisor: Mr Sachet Valjee  
Cc Academic Leader Research: Dr Jean Steyn  
Cc School Administrator: Ms Ayanda Ntuli

Humanities & Social Sciences Research Ethics Committee

Dr Shenuka Singh (Chair)

Westville Campus, Govan Mbeki Building

Postal Address: Private Bag X54001, Durban 4000

Telephone: +27 (0) 31 260 3587/8350/4557 Facsimile: +27 (0) 31 260 4609 Email: [simbap@ukzn.ac.za](mailto:simbap@ukzn.ac.za) / [snymam@ukzn.ac.za](mailto:snymam@ukzn.ac.za) / [mpbuna@ukzn.ac.za](mailto:mpbuna@ukzn.ac.za)

Website: [www.ukzn.ac.za](http://www.ukzn.ac.za)



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**APPENDIX 3 – THE SKOVHOLT & RONNESTAD MODEL (1992)**

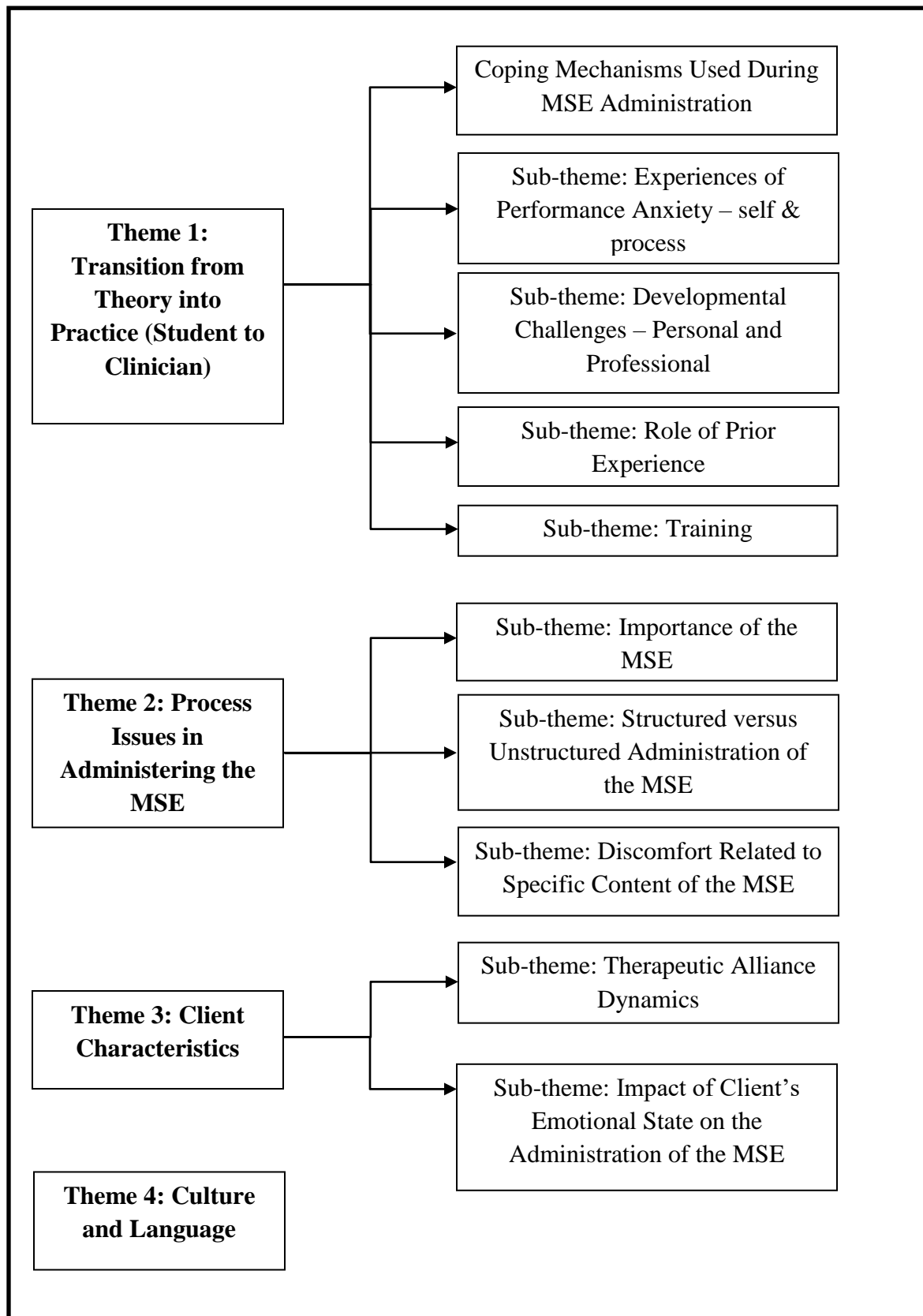
TABLE 1				
Outline of Stage Model				
Categories	Conventional	Transition to Professional training	Imitation of Experts	Conditional Autonomy
Definition and time period	Untrained, may be many years	First year of graduate school	Middle years of graduate school	Internship, 6 months to 2 years
Central task	Use what one naturally knows	Assimilate information from many sources and apply it in practice	Maintain openness at the meta level while imitating experts at the practical level	Function as a professional
Predominant affect	Sympathy	Enthusiasm and insecurity	Bewilderment then later calm and temporary security	Variable confidence
Predominant sources of influence	One's own personal life	Sense of being overwhelmed because of many interacting new and old data bases	Multiple including supervisors, clients, theory/research, peers, personal life, socialcultural environment	Multiple including supervisors, clients, theory/research, peers, personal life, socialcultural environment
Role and working style	Sympathetic friend	Uncertain/shifting while struggling to fit practice with theory	Uncertain while developing a rigid mastery of basics	increased rigidity in professional role and working style
Conceptual ideas	Common sense	Urgency in learning conceptual ideas and techniques	Intense searching for conceptual ideas and techniques	Refined mastery of conceptual ideas and techniques
Learning process	Experiential	Cognitive processing and introspection	imitation, introspection, and cognitive processing	Continual imitation with alterations, introspection, cognitive processing
Measures of effectiveness and satisfaction	Usually assumed, often not of concern	Visible client improvement and supervisor reaction	Client feedback and supervisor reactions	More complex view of client feedback and supervisor reactions

# TABLE 1 (continued)

## Outline of Stage Model

Exploration	Integration Individuation	Individuation	Integrity
New graduate, 2–5 years	2–5 years	10–30 years	1–10 years
Explore beyond the known	Developing authenticity	Deeper authenticity	Being oneself and preparing for retirement
Confidence and anxiety	Satisfaction and hope	Satisfaction and distress	Acceptance
New data bases, i.e. new work setting, self now as professional, multiple other sources	Self as professional elder as new influence, multiple other sources	Experience-based generalizations and accumulated wisdom are becoming primary. Earlier sources of influence are internalized, self as professional elder	Experience-based generalizations and accumulated wisdom are primary. Earlier sources of influence are internalized, self as professional elder
Modifying externally imposed professional style	Role and working style as mix of externally imposed rigidity and internally imposed loosening mode	Increasingly oneself within competent professional boundaries	Being oneself
Personal rejection of some earlier mastered conceptual ideas	An emerging personally selected synergistic and eclectic form	Individualized and personalized	Highly individually chosen and integrated
Reflection	Personally chosen methods	Personally chosen methods	Personally chosen methods
Increasingly realistic and internalized criteria	Increasingly realistic and continued internalization of criteria	Realistic and internal	Profoundly internal and realistic

**APPENDIX 4 - DIAGRAM ILLUSTRATING THE PROCESS OF FORMING THEMES AND SUB-THEMES**





## ***APPENDIX 5 – SAMPLE OF INTERVIEW TRANSCRIPT***

Name of Interviewer: Marc Greener

Name of Participant: INT001

Date: 26/09/2017

Venue: UKZN Psychology Clinic

### **START OF INTERVIEW**

**I: Cool hey (participant name). So, um just to remind you what this is about, umm, I'm going to be interviewing you about your experience of conducting the Mental State Examination with an adult client, so I have a semi-structured interview schedule here with a couple questions to guide us, but what we're mostly going to be doing is watching your video and commenting on the process of what's going on. Um, so when we're watching the video it would be great if you umm, would also feel comfortable pausing it at points and saying what was going through your mind, if you can remember what you were feeling or why you think you did something a certain way or just reflecting on it-**

Participant: Okay.

**I: -and I'll also have a chance to pause and ask questions and stuff. So ya, let's get started. So the first question, have you conducted the mental status examination with an adult client?**

Participant: Uhhh yes I have.

**I: Okay, cool. Could you please tell me a little bit about yourself.**

Participant: About myself?

**I: Ya, like identifying information, that will obviously remain confidential (laughs).**

Participant: Okay well then, not my name?

**I: Ya, whatever, so like age, highest level of education, whether you're single or married, culture, race, religion, all that kind of stuff.**

Participant: Okay, alright. I am a 25-year old, well I'm turning 25 in November-

**I: Mmhmm.**

Participant: -I'm a white, young female. I am currently single-

**I: Mmhmm.**

Participant: -I live in Durban, my highest qualification is now my masters that I'm busy studying-

**I: Yeah.**

Participant: -I've done a Bachelor of Social Science Honours before that, and umm, yes, I am a Christian.

**I: Okay, and what has your experience as a developing clinician been like so far?**

Participant: Umm (laughs), it's been really hectic-

**I: Mmhmm.**

Participant: -umm, very interesting, I think that there's lots of challenges that come along the way, just personal challenges too.

**I: Yeah.**

Participant: -umm, it's a very strange sort of process because you're learning a whole lot of theory and you start taking clients, but I think the biggest thing that gets worked on in masters is really like your own strengths and weaknesses, and the process kind of just brings out things, you know, inside of you-

**I: Yeah.**

Participant: -that you didn't really necessarily know about or you, just you know things that you have to kind of face and work through-

**I: Yeah.**

Participant: -so that you can be effective.

**I: Mmm. Okay. Cool and what was your first experience dealing with an adult client like?**

Participant: Umm well for me it was actually difficult because I had trouble getting continuous cases, I went through a lot of cases that just fell through. I did intake sessions and then like for parents for their children and then it just wouldn't work out because there were legal aspects or something like that.

**I: Yeah.**

Participant: Umm, with this particular client I didn't actually intend to do an intake with her for herself. Initially she wanted to bring in her son for counselling-

**I: Yeah.**

Participant: -but then umm, it just turned out that he was already seeing another psychologist and she was going through difficulties in the family so, we just, we- I suggested counselling to her.

**I: Okay, and what was that session like in general?**

Participant: The whole session?

**I: Just in general, like what was, what was that experience like for you?**

Participant: Umm, it was a good experience. I mean it wasn't so great because she hasn't- she hadn't actually chosen to come in as a client herself so she was obviously quite defensive and didn't want to carry on with the process-

**I: Yeah.**

Participant: -but this session was good because she actually opened up and told me something that she hadn't told anyone that she'd been kind of carrying for a long time-

**I: Yeah.**

Participant: -so it was, it was a good session.

**I: Okay cool. And then, in relation to the video clip which we'll be watching just now, before we watch it, umm, is there anything that stood out to you when conducting the mental status exam?**

Participant: Umm (laughs), well I think all of us were a bit confused about the mental status exam in the beginning, I think it's just very overwhelming because you've got all the information that you're supposed to include in that first intake session in the-

**I: Yeah.**

Participant: -interview and it's kind of like you're trying to see in your mind whether you've covered all the aspects and especially for the MSE, umm, it's a bit confusing but it's umm, like, with what we did is we kind of wrote it down on a page so that you kind of have a guide-

**I: Ya.**

Participant: -to what you're asking and I think that that helps a lot.

**I: Okay, cool. Okay so we're going to watch the video. Umm, and then we're gonna follow up with some questions specifically speaking to the video. Umm so like I said, it would be great if you feel comfortable to just pause at points if there's things you want to say or add, umm that would be awesome. So I think if we just-**

Participant: What sort of things?

**I: So like if you remember something from the session as to-**

Participant: Okay.

**I: -perhaps how you felt when she reacted a certain way or what you were thinking at a certain point or how you felt asking the question. Umm feel free to pause it if anything just pops into your mind.**

**(VIDEO PLAYS)**

**I: Okay so, that first question you asked, “what is the date today?”, she responded and you guys both laughed. Umm, tell me a bit about that.**

Participant: (laughs) Ummm...

**I: What was that like?**

Participant: Well I think just that opening statement that I said where I said “this is kind of routine questions, you mustn’t think that anything you’ve said has brought this on.” I think that really helps when going into the MSE because when you do the full MSE a lot of the questions are very different or strange-

**I: Yeah.**

Participant: -and not what people would generally encounter so I think they’ll feel a bit guarded or defensive if you kind of- it makes them kind of think that maybe something is wrong with them, and umm-

**I: Mmm.**

Participant: -I suppose with the date and time it just seems funny because it seems like something that everyone would know.

**I: Mmm.**

Participant: And I guess I was a bit nervous there as well because it was the first time I was doing it-

**I: Ya.**

Participant: -a, a full MSE with an adult client and so I think it just kind of lightened the mood a bit, umm, ya.

**I: Okay. Sorry just writing this down. Cool.**

**(VIDEO PLAYS)**

**I: So that statement there, “sometimes I even struggle with this one”. What do you think that was- why did you say that?**

Participant: Uhhh, it was because it was the maths question.

**I: Okay.**

Participant: It was the one where you subtract 7’s from 100-

**I: Mmhmm.**

Participant: -and I mean I know that that's quite a difficult one-

**I: Yeah.**

Participant: -ummm, and so I was just kind of introducing it like that because I mean not everybody has really done maths outside of school, umm, but I probably shouldn't have said that, that- that's something that I also struggle with sometimes. I was kind of trying to make it a bit, sort of lighter-

**I: Mmm.**

Participant: -but umm, ya.

**I: Do you think, ya like you said lighter. Do you think with a lot of these questions you have to make the client feel okay with the questions? As opposed to just asking them and seeing their response.**

Participant: I think uhh when you do it initially it seems strange but afterwards you realise that they are useful questions and that you know, some people can surprise you because you may not think that they've really heard voices or experienced things like that but they'll actually come out and say that they have, and you wouldn't have really found that out unless you did the MSE.

**I: Mmm.**

Participant: And so it's, it's not always that strange or that sort of, you know-

**I: Ya.**

**(VIDEO PLAYS)**

**I: Okay so that statement at the end you think that was just trying to make her feel a bit better?**

Participant: Mmm.

**I: So that she didn't feel too awkward or-**

Participant: Ya I think she was struggling, I mean I think you can see that we are both a bit nervous there-

**I: Mmm.**

Participant: -me in my first MSE and I think her just feeling a bit uncomfortable. Umm, ya and she struggled with that which was actually interesting because she'd said that she'd done maths before-

**I: Mmm.**

Participant: -ummm, and so I think in her current frame of mind it wasn't easy for her.

**I: Mmm. And since this interview you've conducted a couple other MSE's with clients-**

Participant: Mmm.

**I: -so, do you find yourself asking those kind of- or saying those kinds of things umm, like you did in the first one like trying to make them feel okay with stuff?**

Participant: Umm I actually haven't done that many, unfortunately.

**I: Ya.**

Participant: I mean I've only done an intake with parents-

**I: Mmm.**

Participant: -and one other adult client.

**I: Mmm.**

Participant: Umm, I wouldn't say that I d- I had the same experience in the MSE I mean I didn't really feel as nervous or-

**I: Mmm.**

Participant: -like laugh about things-

**I: Yeah.**

Participant: -umm, but it was a completely different experience-

**I: Mmm.**

Participant: -in that MSE.

**I: Ya.**

Participant: Because with him, he kind of, he felt like the questions sounded a bit silly so it was completely different-

**I: Yeah.**

Participant: -to this experience.

**I: Okay.**

**(VIDEO PLAYS)**

**I: So how did you feel asking those probing questions after she said "yes I have heard voices", what was that like?**

Participant: Uhh, well I was actually surprised because I didn't think that she would say that she'd heard voices-

**I: Mmm.**

Participant: -so I think that that showed me the importance of those questions, umm, but it was fine to probe after that-

**I: Mmm.**

Participant: -I mean it didn't, it didn't seem strange or anything and I obviously didn't want to make her feel like-

**I: Yeah.**

Participant: -you know, like, like ooh you know, you hear voices. I just wanted to kind of just stay calm and-

**I: Mmm.**

**(VIDEO PLAYS)**

**I: Do you feel that, so that question you asked I've already, all of what you said umm I know you've mentioned this already, do you find that stuff is sometimes repeated in the MSE? That you might have already had.**

Participant: Uhh, well I don't know I mean the MSE has very specific questions, umm and I guess like an MSE's conducted throughout the session almost in terms of their appearance and-

**I: Yeah.**

Participant: -behaviour and thought content and stuff like that.

**I: Mmm.**

Participant: Ummm but I think the MSE is a nice way of kind of, summing it all up or rounding it all up.

**I: Mmm.**

Participant: I mean, some of the questions may seem a bit strange or you know, out of the ordinary but it's- I can see why it's like, sort of a, you know-

**I: Yeah.**

Participant: -compact way of just checking the basics.

**I: Okay, in, in this session particular, did you find it difficult or was it useful that the MSE kind of is conducted throughout the session and you just kind of making mental notes about "oh she said this, I know it's going to come out later in the MSE"? Was that helpful, was it difficult for you to manage that, did you find yourself skipping over stuff and then saying it again here and you know, she's like "well I've already said that". Did that happen so much or did you find it useful that it was flexible?**

Participant: That was a long question. (laughs)

**I: I know, sorry. Did you find it usable- useful that it was flexible?**

Participant: (laughs) No it's fine. Ya it's difficult to remember everything in the session because you can sort of see important things that are coming up sometimes and then you gotta try and remember that for the MSE. But I, I think it's a good thing that you do the MSE because you won't necessarily always find that stuff out in the interview.

**I: Ya.**

Participant: Until you ask those specific questions, I mean as it is it takes a long time to just get a full picture of the client-

**I: Ya.**

Participant: -and what they going through, but umm, I didn't find that it was really repetitive in this MSE. I think this MSE was helpful.

**(VIDEO PLAYS)**

Participant: You can see that she's quite anxious there.

**I: Ya I noticed she put her hands on the side of the chair-**

Participant: Mmm.

**I: -like she was bracing herself.**

Participant: And her legs are also shaking.

**I: Mmm. What was going through your mind? Did you notice that, or did it impact anything?**

Participant: Uhh, I mean I'm not sure if I noticed it in the session, maybe-

**I: Mmm.**

Participant: -umm, I think that, I mean for clients just in general and with her I think it must be difficult to admit those things, if you've kind of been hiding these things that you've like been hearing these voices or you've started to feel really anxious or you've been having panic attacks. I think it can also almost seem like a bit, I don't know, embarrassing, or make you seem weak or-

**I: Yeah.**

Participant: -mentally unwell to kind of admit that all these things have been happening and I think that was the case for her, that she hadn't really wanted to kind of face, you know, the condition that she was in.

**I: Yeah. And for you that kind of helped paint a better picture of what she was really going through.**

Participant: Mmm.



**I: So going back to those specific questions that are very necessary that you wouldn't normally get-**

Participant: Ya.

**I: -you would say is helpful.**

Participant: And I think the one about anxiety too, I'm not sure if that's always included in the short MSE, but worrying excessively I think maybe that is included-

**I: Mmm.**

Participant: -and that's like a good one because you don't always find out that people are having panic attacks unless you actually ask them in the MSE.

**I: Yeah. Okay.**

**(VIDEO PLAYS)**

**I: How did you feel asking these kinds of questions, that were-**

Participant: Uhhhh...

**I: -possibly a little bit awkward to ask?**

Participant: Well I do wish that I hadn't laughed the times that I did in this interview, I mean I, I don't think I laughed like at the serious times when she was telling me some of the things which was good, but-

**I: Yeah.**

Participant: -just overall I mean I guess it was my first MSE but uhh, I don't think it really helps to laugh even if you're trying to make it light-hearted I don't think it's- it's helpful-

**I: Mmm.**

Participant: -in the MSE. Uhhhh the bowel functioning question is always difficult, umm, I think like with her she responded openly and said that-

**I: Mmm.**

Participant: -she'd always had a problem but I don't think that's an easy question to ask-

**I: Yeah.**

Participant: -umm and my supervisor that I have now did kind of say you can- you can maybe put it across as saying like "I'd like to just know a bit about your general functioning in terms of your sleeping, eating-

**I: Mmm.**

Participant: -bowel functioning” so that it doesn’t seem as if you suddenly just asking that question.

**I: Mmm, mm.**

Participant: But I guess you just have to, kind of just remain professional and not umm, not be embarrassed yourself or anything because then it will put them at ease.

**I: Yeah.**

**(VIDEO PLAYS)**

**I: Cool umm, I noticed you didn’t ask about her sexual functioning?**

Participant: Mmmhmm.

**I: Do you think there was a reason you didn’t or did it just slip your mind?**

Participant: Umm, well actually I wasn’t entirely sure that the- I mean when we did the MSE in the beginning that the sexual functioning was in the short MSE at the end.

**I: Mmm. Okay so you followed a specific structure?**

Participant: Ya.

**I: And it wasn’t included in that structure.**

Participant: Mmm.

**I: Okay.**

Participant: But that was something that I did need to find out from her-

**I: Mmm.**

Participant: -and I did get into it in the second session.

**I: Okay. Okay so now there’s just a couple umm, directed questions, or more directive questions. Umm, just to reflect on this whole process. So umm thinking about, umm how you conducted this MSE, umm what did you find went well whilst conducting the MSE with this client?**

Participant: What went well?

**I: Yeah.**

Participant: Ummm-

**I: Anything you found went well.**

Participant: Well I think I managed to get uhh, some good information about the fact that she was having panic attacks umm-

**I: Mmm.**

Participant: -her suicidal ideation, and I think that I was relatively calm and supportive when she was saying those things, just kind of staying with her in that and trying to probe about it a bit more.

**I: Mmhmm.**

Participant: Umm and not coming across as judgemental-

**I: Mmhmm.**

Participant: -so I think that that, those were good points.

**I: Okay, and then what did you find difficult whilst conducting this MSE?**

Participant: I think just the fact that this was the first one. I was nervous, umm, there's nervous laughter which I don't think is very helpful for the overall process-

**I: Yeah.**

Participant: -ummm and also just feeling unsure of the, the whole MSE I think.

**I: Okay cool, and then what would you say was the reason for this particular experience, for what went well and what didn't go well?**

Participant: What do you mean?

**I: So what are the reasons why you were unsure of the MSE, what are the reasons, I know you said it was your first MSE so you were nervous. Umm but perhaps, are there other reasons, more personal characteristics that might have impacted this, maybe it was a result of training or being umm inexperienced. So what kind of things do you think resulted in the MSE going the way that it did?**

Participant: Ummm...

**I: Not saying that it was bad or good, just h- why? Why did it happen like that?**

Participant: That's another long question. (laughs)

**I: It is.**

Participant: Umm well definitely the training, I mean first MSE, umm I think that when you are introduced to the MSE it's a bit overwhelming because you read like a whole chapter or something on the MSE and then you somehow supposed to put this into a format that you can remember and conduct with a client-

**I: Mmm.**

Participant: -so I think that that's a difficult, umm kind of structuring it down. When we went to some of the hospitals recently they gave us like sort of a print out of a basic MSE and I think

maybe if we'd had something like that in the beginning it would have been helpful, I think it would have been very helpful-

**I: Mmm.**

Participant: -for a lot of us. Umm, other than kind of just reading a ch- a chapter on it.

**I: Yeah.**

Participant: Ummm which is very informative but just not easy to actually carry out.

**I: Mmm. And do you think any other things impacted on this experience, like perhaps personal characteristics?**

Participant: Umm, ya I think that, I mean personally I, like when you asked about the sexual functioning, umm I don't think I've always been, I don't know maybe if it's to do with my culture or religion or something but talking about sex is not something you really do on your everyday basis-

**I: Mmm.**

Participant: -and I think it's something I was a bit nervous to actually ask about-

**I: Yeah.**

Participant: -umm and some of these questions I was nervous as well about the client's response but actually she was a lot like, she was pretty open about some of the questions that I thought would be, you know, a bit of-

**I: Sensitive.**

Participant: -a, ya.

**I: Okay cool. Umm, do you think there any other influences that impacted on your ability to conduct the mental state exam? So maybe gender, age, umm cultural differences. You said umm, she didn't have a problem with some of the stuff but you did, so what kinds of things do you think if any?**

Participant: Umm I don't really think so I mean didn't feel anything cultural coming across here-

**I: Yeah.**

Participant: -as such.

**I: Okay and any age or gender?**

Participant: Not with her, I think it probably helped the fact that we were both women. I think she, she might have felt uncomfortable if she was with a man or something. Umm so I think it's, it's obviously different if you asking, you know, an older man or a woman-

**I: Mmm.**

Participant: -those types of questions.

**I: Mmm. So do you think in this case being the same gender helped a lot in being able to connect and understand?**

Participant: To some extent.

**I: Okay. Okay so do you think there were any other influences that you might have forgotten or left out or- is that it?**

Participant: Can't think of anything else.

**I: Okay cool, umm so just in closing. Did you find this interview and its questions understandable, even the long ones?**

Participant: (Laughs) Long questions. Uhh, yes.

**I: Okay cool and was there anything else you want to add or clarify or speak about in relation to the MSE?**

Participant: I think that's about it.

**I: Okay, cool. Awesome, done.**

Participant: Cool.

**END OF INTERVIEW**

## APPENDIX 6 – TURNITIN REPORT

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